Soundings in Tibetan Medicine

ANTHROPOLOGICAL AND HISTORICAL PERSPECTIVES

EDITED BY

MONA SCHREMPF

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REFOCUSING ON TIBETAN MEDICINE

MONA SCHREMPF

Tibetans have long held medicine to be one of the main pillars of their own system of 'sciences' (*rig gnas*). Yet, the complex social history and scope of Tibetan medical knowledge and practices have remained largely unknown to non-Tibetans, despite the fact that some quite substantial and careful studies on Tibetan medicine have been published to date. Until recently, medicine appears to have remained of somewhat marginal interest to scholars within the field of modern Tibetan Studies. A new impulse for a more focused discussion on studies of Tibetan medicine was the goal behind a specific panel at the International Association for Tibetan Studies Seminar at Oxford University, 2003.[1] The present volume is the outcome of this first modest attempt to establish Tibetan medicine closer to the centre of the discipline of Tibetan Studies where it certainly belongs.[2]

Research on Tibetan medicine is still in its infancy, especially when compared with scholarly works on the other great medical traditions of Asia, such as Āyurveda and Chinese medicine. Furthermore, interested parties have often portrayed Tibetan medicine in competing and misleading ways. On the one hand, since Western standards and national interests play a dominant role in the delivery of medicine today, and due to competition with state-supported biomedicine, Tibetan medicine is sometimes presented as a 'scientific' system (in the Western sense),

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[1] As organiser of the panel and editor of this volume, I am very grateful for the institutional support provided by the convenor of the conference, Charles Ramble, and his staff. I also thank The Wellcome Trust for the History of Medicine at University College London for financial support provided to stage the panel.

[2] I wish to acknowledge here the important pioneering work by Fernand Meyer, Ronald Emmerick, Manfred Taube and Elizabeth Finckh. Due to various circumstances, papers by the following presenters in the Oxford panel could not be included in this volume: Kim Gutschow, Janet Gyatso, Susanne von der Heide, Yangga Trarong, and Tenzin Namdul. Janet Gyatso's paper has been published in *Comparative Studies of South Asia, Africa and the Middle East*. The chapters by Henk Blezer, Resi Hofer, and my own were not formally presented at the Oxford panel. Laurent Pordié who unfortunately was not able to attend the IATS conference in Oxford is also editing a book on Tibetan medicine, *Tibetan Medicine in Contemporary Context*.

stripped of its traditional 'supernatural' or religious elements. This is the increasing tendency within both China and the Tibetan exile community. However, on the other hand, Tibetan medicine is still often presented as a rather monolithic cultural tradition, being ancient and unchanged, and therefore 'authentic'. For example, while the *Rgyud bzhi* is invariably cited as the standard source and legitimation for Tibetan medical knowledge as though it were a uniform and unchanging text, in reality it has been constantly edited, revised and reinterpreted by many different users.

This volume attempts to break through such simplified images by bringing together and focusing on new anthropological and historical perspectives on Tibetan medicine. Why might it be fruitful to combine these two approaches? For instance, the institutionalisation and standardisation of Tibetan medicine could be understood as a particular modern development. However, these processes go back to the late 17th century, when the famous medical college of Chagpori (Lcags po ri) was founded in Lhasa and the major medical commentaries were written by Desi Sangye Gyatsho (Sde srid Sangs rgyas rgya mtsho) who synthesised a great many of the medical texts of his day. Thus, it is only by way of gradual and careful comparison of a wider variety of medical texts and practices, and also by careful research on its social history, that we can gain a clearer picture of Tibetan medicine in all its complexity. This includes the influences upon it from other medical traditions of Indian and Chinese provenience, as well as its variety of localised traditions, its interface with other Tibetan healing practices, and finally its increasingly complex relationship with modern biomedicine. Socio-political and historical factors, such as colonialism, state policies and exile, are also important forces that have transformed and continue to shape the theory and practice of Tibetan medicine into the 21st century. They also influence the way in which we understand the history of Tibetan medicine. An examination of these factors and their influence will inform us much more about how Tibetans have understood and engaged with issues of health, illness and healing in any particular time and space. This is what the present volume tries to initiate, by bringing together a wide variety of essays authored by historians and anthropologists, and representing their most recent research on Tibetan medicine.

When we try to define the term 'Tibetan medicine' (*bod sman*) we face a further challenge. We might start with the classical definition of

Tibetan medicine as *gso ba rig pa*, the 'knowledge and practice of healing' or 'science of healing' as expounded by the *Rgyud bzhi*. Traditionally, Tibetan 'doctors' known as amchi (*am chi, em chi*),[3] menpa (*sman pa*) or lhaje (*lha rje*), transmit and practise Tibetan medicine on the basis of the *Rgyud bzhi*. This occurs in two distinctive modes: either privately through 'medical lineages' (*sman pa'i rgyud pa* or *rgyud pa'i am chi*), i.e. from teacher to student inside or outside family lineages; and/or through state or monastic institutions, i.e. monastic medical colleges or the Mentsikhang (Sman rtsis khang).[4] The term *amchi* is a loan word from Mongolian and of possible Turkic origins, and has been used in the Himalayas as a signifier for the whole system of Tibetan medicine. Thus, especially in Ladakh, Spiti and the Nepal Himalaya, Tibetan medicine is colloquially rendered as 'amchi medicine' or '*Rgyud bzhi* medicine'. However, neither of these professionally defined terms nor the more general designation *gso ba rig pa* account for other important Tibetan healers and their healing practices, such as 'tantric practitioners' (*sngags pa*) and lamas (*bla ma*), or 'spirit mediums' (*lha pa*). Additionally, there are other types of healing specialists such as bonesetters, and various types of 'diviners' (*mo pa*) and 'astrologers' (*rtsis pa*) who may be consulted for diagnosis or the right choice of treatment among Tibetan patients. With the exception of Tibetan healing practices in Ladakh and Nepal, many of these other types of specialists have disappeared from the field of our inquiry, and there is a reason for this. For one thing, they have become increasingly marginalised by state policies in China. But they have also been marginalised by institutionalised and standardised Tibetan medicine in both Tibet itself and in the Tibetan exile community because of increasing scientisation or secularisation of medicine, i.e. the need to adapt to modern 'scientific' standards stripped of any supernatural content.

Furthermore, there is also a danger of 'traditionalising' Tibetan medicine by neglecting the strong influence of modernity upon its the-

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[3] Since the word amchi occurs frequently in this volume, and since it has already become such a widespread expression for a 'doctor of Tibetan medicine', I will use it herein in the same way as the common anglicised word lama.

[4] The term for Tibetan Hospital, Sman rtsis khang, literally means 'Medicine Astrology House'. The common phonetic version 'Mentsikhang' will from now on denote the one in Lhasa and other places of the TAR whereas the anglicised version 'Men-Tsee-Khang' is commonly used for the 'Tibetan Medical and Astro Institute' in Indian exile in Dharmasala and its various branch institutions.

ory and practice during recent times. In general, the preservation of Tibetan medicine as a distinctive tradition has been stressed within the context of various political projects, not only within China and in the Tibetan exile, but also throughout various parts of the Himalayas. However, there is also a wide range of ways in which 'biomedicine' or 'Western medicine' is actually integrated or practiced together with Tibetan medicine. This is especially evident, for example, when we compare Tibetan medicine as practised in Britain and the United States with the way it is practised at the Lhasa Mentsikhang or the Dharamsala Men-Tsee-Khang, where X-ray machines and stethoscopes are used side by side with pulse diagnosis, for example. The Tibetan terminology used in China for 'Western medicine' or 'biomedicine' (Chin. *xiyi* or *xiyao*) reveals the actual underlying dominant structure of state subsidised medicine. Western medicine is here identified as 'Chinese medicine' (*rgya sman*) or 'medicine [from] outside' (*phyi lugs sman*), that is, as a foreign and perhaps even imposed system.[5] The semantically equivalent Tibetan term *tang sman*, in which *tang* designates the Communist Party, clearly signals the actual political dimension of biomedicine in China's Tibet.[6]

Beyond terminology and its connotations, we find that the integration of Tibetan medicine with biomedicine on the Tibet Plateau is also a highly creative frontier of theory and practice, just as it is in exile or the Himalayas. Many examples from different regions of Tibet illustrate this point, where biomedical and traditional Tibetan diagnosis and therapy are integrated in various ways. While amchi might palpate the pulse in a small rural clinic, they may also have to administer biomedical drugs to their patients there because of the local shortages and high costs of Tibetan medicine. Yet, in another locality, amchi who diagnose illnesses with the help of a stethoscope, sphygmomanometer or X-ray still prescribe only Tibetan medical drugs that are more readily available there. Even privately practising senior lineage doctors who produce their own medicine by hand according to traditional recipes, and who know nothing about biomedicine, still have to deal with biomedicine in various ways, be it to treat patients who have taken Western

[5] In contrast, the Chinese term for traditional Chinese medicine (Chin. *zhongyi*) is generally defined as being separate from 'Western medicine' (Chin. *xiyi*). Both the term for and the practice of so-called 'Traditional Chinese Medicine' or TCM are very much products of early Communist China and were aspects of its nationalist project.

[6] I thank Sienna Craig for this reference and her thoughts on this issue.

medicine previously or patients who need to be sent to hospital for an operation. Another, more subtle issue, is the recent production of Tibetan medical literature (as translations, editions and textbooks) with resort—whether consciously or not—to biomedical terms to explain conceptually and culturally different notions in Tibetan medicine.

Some of the most compelling issues that are addressed throughout many of the chapters in this volume concern epistemological claims and meanings relating to both Tibetan medicine and biomedicine—the former being taken in its broadest sense, thus including culturally Tibetan notions of the body, health and illness, and the latter being intrinsically involved in all kinds of translation processes, whether in historical exegesis or anthropological studies, though again, in very different ways. Thus, for example, the anthropological research in this volume revolves around the general themes of secularisation, professionalisation, standardisation and 'scientisation' of Tibetan medicine in both Tibet and the Tibetan exile. Moreover, the different kinds of cultural, political and social forces that are at play in the locally diverse practices of Tibetan medicine and among regions of ethnically Tibetan populated areas of the Himalaya and China are also revealed. The relationship between medicine, science, politics and religion is thus a reoccurring theme, and this includes the impact of politics and commercialisation upon medical transmission and practice and the production of Tibetan medicine. Issues of medicine, identity and place are discussed, as well as popular medical knowledge and social change. Tibetan medicine is also investigated as it is practised and applied in very different cultural contexts in the West. In the section on historical research, historical translations, transitions, and changes in terms of the content and styles of transmission of Tibetan medical texts are all important issues that the chapters address in various ways.

Part One of this volume deals with the diverse manner in which Tibetan medicine in China, in Indian exile and also in Nepal has been influenced by the various impacts of modernities—whether in the form of colonial powers, by displacement of refugees into exile, through the influence of international aid agencies or by newly introduced modern technologies. Part Two deals with the topic of medical knowledge and its transmission, professionalisation, and questions of identity among Tibetans across geographical and national boundaries in diverse contexts of Tibetan culture. Part Three is dedicated to the theme of connections between various body images, practices, and cosmologies (espe-

cially belief in spirits) in Tibetan societies, and the different ways in which mental and physical illnesses are understood in Tibetan and Western medical contexts. Part Four is solely dedicated to important historical and philological aspects of Tibetan medicine, critically assessing literary sources or combining written textual with oral sources. Among these texts are medical histories (*khog 'bugs*), including a little-known source on Indian medicine from an early Tibetan perspective, and the important medical commentary known as the *Blue Beryl* compiled by Desi Sangye Gyatsho, whose works became so very influential upon the development of Tibetan medicine from the 17th century onwards. Thematically, the issues represented in Part Four encompass a comparison between Tibetan and Chinese sphygmologies, the history and identity of a specific Tibetan medical school known as the Byang lugs, and Tibetan embryological theory as found in medical and religious literary sources. An overview on desiderata concerning a more concise history of Tibetan medicine rounds up this volume.

Even though Part Four is entirely dedicated to the earlier history of Tibetan medicine, several of the chapters in the first three more anthropologically oriented parts do address important historical dimensions, mainly focusing upon socio-cultural and political issues of modernity during the 20th century. Likewise, some historical exegeses in Part Four include a social history of ideas, acknowledging the importance of socio-cultural inquiries. Consequently, this volume is open to both anthropological and historical soundings in Tibetan medicine, in the conviction that both approaches can and should be mutually and fruitfully combined in order to elucidate and reinforce one another.

PART ONE:
TIBETAN MEDICINE AND MODERNITY

HIMALAYAN MEDICAL ENCOUNTERS: THE ESTABLISHMENT OF BIOMEDICINE IN TIBET AND IN INDIAN EXILE

ALEX MCKAY

INTRODUCTION

One of the key factors that left Tibet unprepared to face the Chinese communist regime in 1950 was their failure to modernise state structures and social processes during the preceding decades.[1] The period between 1913 and 1947, when the Tibetan state enjoyed de facto independence with some support from the British imperial Government of India, had offered Tibet a 'window of opportunity' in which to reform and reconstruct its institutions in line with the demands of modernity. During the 1920s, however, Tibet turned away from modernisation, and attempted to maintain its traditional socio-political forms, a decision which, in retrospect, can be seen to have left it fatally unprepared to deal with the modern Chinese state. While there were certainly economic restrictions on modernisation, the main opposition to modernity arose from the conservative nature of Tibetan socio-religious institutions and understandings. One area in which the Tibetan's failed encounter with modernity may be examined in detail is the medical sphere; despite the presence of British biomedical institutions in Tibet throughout the period from 1904–49, there were, at the time of the Chinese invasion, no Tibetan biomedical practitioners or institutions in Tibet. The failure to institutionalise a modern medical system mirrored similar failures in spheres such as the military, educational, and political, and is thus a microcosmic example of the wider process.

This chapter is therefore designed to provide an overview of the Tibetan encounter with biomedicine[2] during the first half of the 20th century, while the second part of the paper will briefly survey the issues

[1] Here I accept the conclusions of Dhondup 1986 and Goldstein 1989.

[2] I use the word biomedicine (popularly known as 'Western medicine') to describe the medical system predominant among the various Western agencies involved in the British imperial project in South Asia.

arising from the practice of 'Tibetan medicine'[3] in the exile community since 1959, in order to demonstrate how Tibetan cultural formations and adaptations have operated in the medical sphere. The principal sources for this study are the records of the medical institutions of the British imperial state and it is, of course, necessary to read these sources with due caution. The Tibetans were not passive recipients of biomedicine, and dynamic aspects of the encounter may be discerned, along with both resistance and adaptation, within the imperial records.

The Pre-Younghusband Era

There are indications that by 1903–04, when the Younghusband mission invaded Tibet, Western medicine had already gained some favourable repute among Tibetans. Not only had European travelers and missionaries demonstrated the efficacy of their medical practices in and around Tibet's frontiers, but in addition, 19th century Tibetan traders, pilgrims, and envoys had traveled to imperial centres such as Calcutta and Peking where biomedicine predominated at the imperial and even local elite level. While these things are difficult to quantify, it does appear that some demand for Western pharmaceuticals and aspects of biomedical practice had already established roots in Tibet in the pre-Younghusband era.

But the Tibetan state at that time lacked any semblance of a public health system in the European understanding. Medical services were provided by monastic and village-level practitioners of traditional medical systems, and scientific advances in the West, such as germ-theory, were entirely unknown there.[4] While the natural environment of much of Tibet was a healthy one, in which the extreme cold meant an absence of malarial infection and of many of the water-borne diseases that ravaged India, Tibet was largely defenseless against epidemic diseases

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[3] The definition of 'Tibetan Medicine' is also problematic; as an organic cultural system, its boundaries are, and historically have always been, fluid. The term is used here in the general sense to denote the medical practices and understandings of the Himalayan peoples of Tibetan ethnic origin.

[4] Critical studies of the structures and understandings of pre-1950 Tibetan medical systems are only now beginning to emerge; of particular merit in the historical discipline are Karmay 1989 and Meyer 2003; for an insider's view, see Rechung Rinpoche 1973.

such as smallpox that regularly ravaged the country, child-mortality was extremely high and venereal disease was widespread.[5] Without entering into the question of the efficacy of Tibetan medical practices, it is safe to say that there was an enormous potential appeal for biomedicine there.

The Younghusband mission itself played a part in introducing Tibetans to both the ideals and practices of biomedicine. British sources often note that during the mission, the Tibetans were greatly surprised when the imperial medical staff treated the wounds of Tibetan prisoners. The insinuation is that battlefield casualties in that region expected to be put to death. The evidence for this is mixed, many of Zorawar Singh's troops who were captured by the Tibetans were apparently treated reasonably, but reports from the Sino-Tibetan front suggest displays of compassion were less common there. In any case, the British medical services probably did gain goodwill from their wounded captives, and throughout the mission they also offered free medical services, including vaccination against smallpox, to the civil population.

By 1904 the main contours of biomedicine had been introduced from the metropolis into British India and the biomedical system had become hegemonic at state level in India. There were four main agents behind its spread from the subcontinent into the Indo-Tibetan

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[5] 3–5,000 monks, for example, were reported to have died of smallpox in Lhasa in the winter of 1900/01 (National Archives of India [hereafter, NAI], Foreign Department [hereafter, FD], External B, May 1906, 156–58, J.C. White, Political Officer Sikkim, to Government of India, 5 February 1906).

Mrs Guthrie, a nurse married to an IMS (Indian Medical Service) doctor in Lhasa, Major James Guthrie (in the context of discussing a woman whose previous five children had all died), recorded that "as far as we could discover the infant mortality [rate] was very high at all levels of society, possibly as much as 40% to 50%, but there are no official statistics" (see 'Everyday Life in Yesterday's Tibet', unpublished manuscript by Mrs R. Guthrie, in the possession of Mr Chris Guthrie, p.183, entry of 6 May 1948). This work is based on Mrs Guthrie's letters from Tibet, and replicates some of that correspondence, of which the originals do not all survive. Concerning child mortality see also Taring 1983: 109.

Estimates of venereal disease rates reach an extreme with the 1930 claim that "it would be no exaggeration to say that quite 60% of the population of Lhasa are suffering from it" (Oriental and India Office Collection [hereafter, OIOC], L/P&S/10/1113–8573, medical report by Dr. Sinclair IMS, attached to Lhasa Mission Report dated 18 November 1930).

Analysis of the IMS medical reports for the period 1904–47 indicates that in actuality, 10–15% of patients attending the IMS dispensaries suffered from venereal diseases.

Himalayas. First, there were commercial agents promoting the sale of biomedical products and pharmaceuticals, although the lack of sources in this regard makes their impact difficult to judge. Secondly, there were medical missionaries. While the missionaries were not permitted to enter Tibet, in certain regions—Chamba state for example, in the western Himalayas—the missionaries were the prime agents for the introduction of biomedicine. Another group of considerable importance in this process were European travelers to remote regions. While the majority of these lacked any medical qualifications they frequently offered biomedical treatment to the indigenous peoples as a means of obtaining their goodwill. In published accounts of their travels they often added a list of medicines they recommended future travelers should take with them to Tibet.[6]

But the most significant agent behind the expansion of biomedicine into Tibet was the British imperial Government of India. The commercial agents promoted biomedicine for economic reasons, the missionaries partly as a charitable act, but also explicitly as a means to gain conversions, and travelers introduced it as a means to ingratiate themselves with their hosts. But the imperial government promoted biomedicine in Tibet primarily as an explicitly political strategy.

The Political Context

During the 19th century the British Indian empire expanded until it controlled states that shared more than 2,000 miles of frontier with Tibet. In addition to the imperial territory to the south of the Himalayas, there were both political and missionary bases in Chinese territory to the east and west of Tibet.[7] From these centres European influence could be spread into Tibet. In response, perceptively fearing that contacts with the imperial power would undermine their socio-political religious system, and lacking the military power to defy the British empire, the

[6] See, for example, Thomas 1950: 319–20.

[7] The Government of India maintained a 'listening post' at Kashgar from the late 1880s onwards. The Christian missionaries in China who established a chain of mission stations on the eastern and north-eastern borders of Tibet also contributed information on Tibet to the Government of India through various channels. While the Government of India opposed the entry of missionaries into Tibet, they were thus part of the imperial project and were certainly seen as such by the Tibetan authorities.

Tibetans (with Chinese assistance and encouragement) sought to isolate themselves from the British, closing their frontiers and refusing to allow diplomatic communications from their new neighbours.[8] But the imperial government sought both to open Tibet to Indian trade and to protect their empire against any threat of Russian influence from the north. Thus, in 1903, after the Tibetans had rejected all British diplomatic overtures, the Viceroy of India, Lord Curzon, despatched the armed mission under the diplomatic command of the Indian Political Officer Francis Younghusband which forced the Tibetans to accept British trade and diplomatic influence.

A permanent British-Indian diplomatic presence was established in Tibet as Younghusband's forces withdrew in September 1904. A so-called 'Trade Agency' was opened, which was in fact a diplomatic mission staffed by, and under the control of, imperial India's diplomatic service, the Foreign and Political Department. In deference to Tibetan desires for isolation, however, the Trade Agency was established not in the Tibetan capital of Lhasa, but in Gyantse, 120 miles southwest of the capital. The first British agent to be posted there was Younghusband's Intelligence Officer and 'right-hand man' on the mission to Lhasa, the Political Officer Captain (later Lieutenant-Colonel) 'Frank' O'Connor.[9] The duty of a Political Officer under the imperial government system was to establish friendly personal relations with the authorities of the indigenous state in order to influence them to follow policies advantageous to British imperial interests. O'Connor thus set out to befriend the Tibetan elites, and to demonstrate British goodwill in the aftermath of the conflicts arising from the Younghusband mission.

In the early years of the British period in India, Political Officers travelling in remote areas were accompanied by a doctor in case they fell ill. The British had soon found that the doctor's provision of medical services to the indigenous peoples, both elites and non-elites, could obtain considerable goodwill for the Political Officers.[10] Thus, by the

[8] For an attempt to understand the Tibetan perspective on 19th century British expansion through the use of British sources, see McKay 2003.

9 Regarding the establishment and history of the British positions in Tibet, see McKay 1997.

[10] "It is a well known principle that medical officers are attached to our Consulates and Agencies in remote localities primarily on account of political considerations" (NAI, FD, External A, 1906 Sept., 40–46, File note by 'R.S.B. & R.W.S.', 29 May 1906).

20th century, Medical Officers accompanying Political Officers actually devoted most of their time to treating the local peoples. They were entitled to charge fees for private consultations with the local elites,[11] but their services were provided free to the general populace at clinics attached to political agencies, or in camps set up while travelling.

This experience in British India meant that imperial strategists were well aware that the provision of free biomedical services was a simple, economic and highly effective means of obtaining the goodwill of the indigenous peoples, despite various cultural difficulties that arose from the imposition of biomedical practices in social contexts very different from those of the West. Once they had established a position in Tibet, therefore, the British sought to use biomedicine as a means to establish a good relationship with the Tibetans. When the Gyantse Trade Agency was opened a large house was rented for use as a hospital, and a Medical Officer, Captain Robert Steen, was stationed there. Steen's primary role was clearly understood by all parties involved in the British endeavor to be a political one—his medical practice was to enhance the British imperial project. Francis Younghusband had supported the establishment of a Gyantse dispensary precisely because it was "extremely desirable on political grounds"[12] and as O'Connor explained,

> It seemed only right that an officer of the medical service should be left at Gyantse ... with an eye far more to the political than the military exigencies of the case.[13]

This close relationship between the medical and political roles of the European officers in Tibet was most clearly demonstrated by the career of Lieutenant-Colonel Robert Kennedy, Gyantse Medical Officer from 1907 to 1910. By that time Tibet had ceased to be an important issue in British Indian diplomacy, which meant that ambitious Political Officers did not want to be posted there. From June to December 1909, in the

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[11] The differing facilities offered to local elites were justified on the grounds that "The better class of people naturally dislike mingling with the poorer classes in hospital" (OIOC, L/P&S/7/229–923, Annual Report of the Gyantse Civil Dispensary, 1 April 1908—31 March 1909).

[12] NAI, FD, 1906 External B, March 19–31, file note by Francis Younghusband, 4 Nov. 1904.

[13] NAI, FD, 1906 External A, Sept. 1906, pp. 40–46, W.F. O'Connor to Government of India, Foreign Department, 25 March 1906.

absence of a suitable diplomatic candidate for the position as Gyantse Trade Agent, Kennedy actually served as both Political and Medical Officer.[14]

Biomedicine in Tibet

The establishment of the British hospital at Gyantse in October 1904 marked the formal introduction of biomedicine, in the sense of it being the first biomedical institution in Tibet. In the ensuing decades, officers of the Indian Medical Service offered biomedical services to Tibetans from their Gyantse base as a part of the British imperial relationship with the Tibetan state. Until the establishment of a British mission in Lhasa in 1936–37, Gyantse remained the centre of British activity in Tibet, and the hospital there was the centre of biomedical activity. A succession of 23 officers of the Indian Medical Service served there down to 1947. In 1940, however, a new post of Civil Surgeon for Tibet (and Bhutan) was created, which effectively was that of the Medical Officer to the British mission in Lhasa. Four British officers occupied that post in the ensuing decade as the focus of British activity moved to Lhasa.[15]

Residence in Lhasa greatly improved British access to the Tibetan ruling class, access essential to imperial strategies of power. As was the case elsewhere in the Empire, the indigenous elites were targeted as the key to the acceptance of both the imperial presence and their ensuing promotion of Western modernity. Once the elites were converted, the people followed. Persuading the Tibetan ruling elites to adopt biomedicine might be compared to persuading the Tibetan elites to adopt Buddhism many centuries before. In neither case did that mean that the older systems vanished, but at elite and state levels the new systems became predominant. Thus by the end of the British period, biomedicine appears to have become the first resort for much of the central Tibetan aristocracy.[16] The reactions of the non-elite classes to biomed-

[14] Kennedy left Tibet in March 1910, being succeeded as Gyantse Medical Officer by Captain D.M.C Church, who remained there until June 1911. In 1921, Kennedy joined the British Political Officer Charles Bell during his year-long stay in Lhasa.

[15] For a list of the officers who served in Gyantse and Lhasa, see McKay 1997: 235–37.

[16] See, OIOC, Microfiche 540, page 54; "Report on medical work in Lhasa—January to July 1943".

icine are more difficult to judge, but the continual increase in the numbers of Tibetans having resort to the British medical facilities does suggest a growing acceptance of biomedicine.[17]

The monastic elites seemed to have proved most reticent to resort to biomedicine, but the Reting Regent availed himself of British treatment for many years and the Dalai Lama himself was treated for measles in 1943. A couple of years later the British doctor found himself called in to operate on the Dalai Lama's peacock, with the young Dalai as an interested witness to the surgical removal of a cyst from the peacock's eye![18]

Vaccination and STD Issues

Smallpox was originally the Tibetan medical issue of most importance to the British. An outbreak of smallpox in Lhasa in 1900 had spread south across the frontier into British territory, forcing the closure of the passes and the suspension of trade. Both the health and the economy of the empire were damaged and the British consequently sought to create a *cordon sanitaire* against smallpox beyond their frontiers. A smallpox vaccination campaign was thus instituted soon after the opening of the Gyantse hospital and large numbers of Tibetans were vaccinated, including the Sixth Panchen Lama and most of his court. Whereas in the neighboring Himalayan states of Sikkim and Bhutan the British enjoyed both the political authority to introduce vaccination and the support of the local elites in doing so, the situation in Tibet was more complex. Not only did the British lack the political authority to enforce vaccination in a state beyond India's borders, but they also faced objections to vaccination campaigns from the acknowledged suzerain power in Tibet, the Chinese, who claimed that such campaigns represented illegal interference in Tibet's internal affairs.[19]

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[17] In 1913 (the first year after the departure of the Chinese from Tibet) there were 104 inpatients and 303 outpatients at the Gyantse dispensary. By 1947, the annual numbers comprised only 17 inpatients, but just over 4,000 outpatients; see OIOC, L/P&S/10/218-2684, Annual Report of the Gyantse Civil Dispensary, year ending December 1913; L/P&S/12-4166-7049, Annual Report of the Gyantse Civil Dispensary, year ending March 1947.

[18] See McKay (1997: 168); concerning the Regent's resort to biomedicine, see Lhasa Mission report, L/P&S/12/4201-4422, week ending 20 August 1944; and Lhasa Mission report, L/P&S/12/4202-4413, week ending 26 May 1946.

[19] NAI, FD, Secret E, February 1907, 295–353, Political Officer Sikkim to Government of India, 7 December 1906.

Chinese objections caused only a brief hiatus, however, for the Chinese themselves were modernising on biomedical lines and also sought to introduce vaccination into Tibet. They were, in any case, expelled from Tibet in 1912 and by the time they returned in the 1930s the issue was less urgent. While the nature of Tibetan society at that time was such that vaccination of the entire population was unrealistic, the Indo-Tibetan trade routes at least, which were the primary concern of the British, became largely free of the disease by the 1920s. Yet the British sources do indicate that the apparently obvious benefits of vaccination were not universally accepted by the Tibetans. In 1910, for example, two Tibetans who had been trained as vaccinators by the British were found to be taking bribes not to vaccinate people. In addition, there is a reference to 'guile' in persuading the Tibetans to accept the treatment, along with references to monastic opposition to biomedicine generally.[20]

While in the absence of Tibetan sources it is difficult to isolate the causes of any resistance to vaccination, one potential factor encouraging resistance in the Tibetan reception of biomedicine generally was the fact that the main preservers of the existing social structure were the monastic powers, among whose ranks were those who had an economic and sociopolitical interest in the Tibetan medical system. With the influence which the monasteries enjoyed throughout Tibetan society, these monks were potential leaders of opposition to biomedicine, and where the British sources do indicate resistance to their medical innovations, it is the monks who are blamed. The 1911 report, for example, states that

> This comparatively few number of patients is explained by the opposition of the Lamas, who put obstacles in the way of people coming for treatment. The reason is not far to seek, as the dispensary interferes with the fees of the Lamas who are exorcists for all manner of ghosts and demons to whom disease and even injury are universally ascribed.[21]

[20] OIOC, L/P&S/7/241-1058, Annual Report of the Gyantse Civil Dispensary 1910; L/P&S/7/249-1151, Annual Report of the Gyantse Civil Dispensary 1911; MSS Eur F157-224a (Bailey collection), unsourced newspaper obituary of Lt-Col. R.S. Kennedy, presumably by F.M. Bailey.

[21] OIOC, L/P&S/7/241-1058, Gyantse Annual Report, 1 April 1909–31 March 1910.

There was a general tendency to demonise an undifferentiated body of opinion under the heading of 'the monks' and to attribute all Tibetan resistance to them rather than to acknowledge broader concerns. But it was an issue of genuine medical concern to the British that only when the monks had "experimented and failed" did they send patients for biomedical treatment, by which time the patients were often in a very poor state.[22]

This problem was to be common throughout the British period. Particularly in the early years, it seemed that Tibetan patients, or their indigenous physicians, often—perhaps generally—used biomedicine as a strategy of last resort. While the noticeable efficacy of biomedicine was soon acknowledged in certain areas—such as surgical matters, or the prevention of smallpox—the Tibetans maintained their faith in the efficacy of indigenous treatment for many other conditions. In other words, the Tibetans routinely sought treatment within indigenous practices, but would attend biomedical facilities for those conditions where biomedical treatment was considered superior.

The Tibetans' continuing resort to indigenous practitioners suggests that we might need to read the records of treatment at biomedical facilities as indicative not of overall local health patterns, but only as a record of those conditions Tibetans regarded as best treated within the biomedical system. This may lead us to review that feature of Tibetan health that is most commented on in the reports by medical practitioners in Tibet. Venereal disease is usually described there as being endemic, and as having made up much of the caseload of the imperial medical staff in Tibet throughout the British period. The numbers treated certainly increased during the period 1904–47, although it was noted that the Chinese soldiers then present in Tibet made up the majority of the cases in the early years.[23] The question thus arises as to whether these figures do represent a guide to the percentage of medically afflicted Tibetans suffering from venereal diseases, or whether they represent an indication that Tibetans—following the Chinese—quickly came to regard the biomedical treatment for STDs as more effective than that offered by the indigenous medical systems and thus resorted to biomedicine for that specific complaint.

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[22] OIOC, L/P&S/7/249-1151, Gyantse Annual Report, 1 April 1910 – 31 March 1911; and attached Dispensary Report, year ending Dec. 1911.

[23] *Ibid.*

In considering the evidence, we may note that the British reports display no prurient concerns here, nor was the issue used in the sort of public discourse where opinions of the Tibetans were formed. It was knowledge that remained largely within the imperial system, so the concern with the issue may be considered genuine, and the medical practitioners as prosaically concerned with the practical problems of medicines and treatment. Given that no alternative statistics exist to enable us to form a broader understanding of the issue, we can only conclude that the British figures should be treated with some caution. Once again, this is characteristic of the wider situation—trade figures for example, being similarly questionable.

The Expansion of Biomedicine

In addition to Gyantse, two smaller medical establishments had also been created after the Younghusband mission. One was a clinic at Yatung, in the Chumbi valley just over the border from Sikkim, and the other a dispensary at far-off Gartok, in western Tibet, at which places the British had opened smaller trade agencies. In addition, a dispensary was opened at Phari, north of the Chumbi valley, in August 1905.[24] The medical establishments at these locations were generally under the charge of an Indian Hospital Assistant.

Whereas in Sikkim the initial foundation of an imperial medical centre at the capital of Gangtok had been followed by the gradual dissemination of dispensaries throughout rural centers, Phari remained the only addition to British biomedical establishments in Tibet until a hospital was established in Lhasa in the 1930s. Both economic restrictions and political considerations acted against any British efforts to expand biomedical facilities in Tibet and there appear to have been no moves by the Tibetans to introduce any form of biomedicine at state level until after the expulsion of the Chinese from Tibet in 1912, when the 13th Dalai Lama took power over an autonomous Tibet.

The British certainly encouraged the idea of biomedical development. This was a part of the imperial efforts to guide Tibet on the path of modernisation on the Western model. One aspect of that model was the development of a state public health system centred on hospitals

[24] NAI, FD, External B, Aug. 1905, 227–28, various correspondence.

and medical clinics, and in 1910–13, when the 13th Dalai Lama was in exile in India he must have been made aware of the benefits of the system under development in India.[25] After the Dalai Lama had returned to Tibet, a public hospital—the Mentsikhang (Sman rtsis khang, literally 'Medicine and Astrology Building', usually referred to as 'Medical and Astrological College')—was opened in Lhasa in 1916. The treatment provided at this hospital, however, was with indigenous Tibetan medicine, suggesting a more nationalist and traditionalist path of development than the British model intended, although economic factors may also have been involved.[26] Public toilets were also constructed in Lhasa in the 1920s, but these seem to have been an Indian rather than a Tibetan public health initiative,[27] and biomedicine was to remain the preserve of foreign practitioners down to the Chinese takeover of Tibet in 1950.

The indigenisation of biomedicine that the British sought did not occur, in the short term due to the lack of Western educated Tibetans, and in the wider context due to the Tibetan state's rejection of modernity in the 1920s. The question of education is an important one, in that the practice of biomedicine implied the acceptance of a world view very different from that of the Tibetans at that time. Thus an education along Western lines came to be seen as an essential precursor of an indigenous Tibetan biomedical system and such efforts in this direction as were politically and economically possible were made by the British officials dealing with Tibet. But as of 1947 their efforts had borne very little fruit indeed. Only a handful of Tibetans in Tibet itself had received any Western education, and none appear to have been trained to any level in biomedicine.

Geoffrey Samuel, however, has suggested that the founding of the Mentsikhang in Lhasa was a significant step "from the spiritual to the pragmatic in the practice of Tibetan medicine. In entering a state system, Tibetan doctors were preadapted to the pragmatic encounter with Western biomedicine in India".[28]

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[25] The compassionate aspect of a public health system at least must have been considered appropriate to the Lhasa Government.

[26] I have not been able to locate any references to this hospital in the British sources.

[27] Laden La papers, in the possession of Nicholas and Dekyi Rhodes (London).

[28] Samuel 2001: 262.

Interaction in the British Period

In discussing the interaction between biomedicine and Tibetan medical systems, we must consider the timing of the initial encounter. In the 18th century, British and Indian medical understandings had been far from incompatible. There was scope for interaction and a general belief existed among Europeans that local diseases were best treated by local practitioners. In the 19th century, however, with the post-Enlightenment rise of Western scientific enquiry and, in the wider context, the increasingly important power differentials between coloniser and colonised, the two systems came to be seen by the British as incompatible, with the Indian systems stigmatised as 'primitive' and 'unscientific'.

The Viceroyalty of Lord Curzon—1899–1905—may be seen as the 'high tide' of British imperialism in South Asia, and Curzon despatched Younghusband to Lhasa in this time of imperial certainty, when the British were convinced of the total superiority of their scientific knowledge and the inevitability of the ultimate triumph of Western knowledge over 'primitive' knowledge. We might acknowledge that in addition to the colonial context of this process, there was a humanitarian aspect to their understanding; the efficacy of biomedicine would, the British believed, not only be obvious to the indigenous peoples, but would also eliminate or alleviate many of their medical sufferings. These imperial certainties left no room for serious consideration of the Tibetan medical systems. The British Medical Officers operated in complete confidence in biomedicine, and the fact that they served maximum terms of two years in Tibet probably further restricted any possibility of their developing any interest in local practices. As they were not required to learn Tibetan, they were also isolated from even the elite textual medical culture of Tibet.

Given the prevailing British mentality, there could be few if any concessions to indigenous medical understandings. To the British imperial doctors, 'Tibetan medicine' was the undifferentiated 'Other'. But through the use of Sikkimese medical staff in Tibet (at the rank of Hospital Assistant/ Sub-Assistant Surgeon), the British sought to demonstrate that their medical system could be mastered by anyone, and there is some evidence to suggest that the Tibetans may have felt more comfortable in dealing with the (Buddhist, and ethnically Tibetan) Sikkimese biomedical staff than with the British.

There are occasional references suggesting individual Tibetan's interest in biomedicine, a monk in the 1920s requesting that the British Medical Officer teach him surgery, for example.[29] We also read of the growing popularity of Western medicines and particularly injections within Tibet, suggesting the first tentative steps towards syncretism. But whereas in India the British colonial state had the power to create hegemonic structures that channelled indigenous resources and understandings into biomedical predominancy at state level, they lacked that power in Tibet and syncretism was tentative and gradual, to be compared perhaps, more to the situation in India in the 18th century than in the 20th.

While biomedicine remained a foreign system to Tibetans during the British period, increasing numbers of Tibetans did attend the British hospitals. I have previously suggested that the free provision of biomedicine was a crucial factor in its popularity,[30] particularly among the non-elite classes, but, leaving aside the issue of efficacy, two other factors may be considered. One is the tentative growth of a new class of urban Tibetans who were open to aspects of modernity, and it is from that class incidentally, that the first Tibetan biomedical practitioners arose in the exile community in the 1950s. The other factor that may have increased the popularity of biomedicine was the British incorporation of Tibetan cultural beliefs into the periphery of their practice. By the 1940s, they were increasingly willing to allow culturally appropriate adaptation of the biomedical system. Dr. James Guthrie, the last Western medical officer in Lhasa, for example, in attending a birth, raised no objections when the patient's family asked that the mother be allowed to take a dose of powdered rhino horn. This was considered by the Tibetans as beneficial in inducing a healthy birth and Guthrie's principle was that anything that was not actually harmful in the scientific sense might be permitted.[31] He similarly encouraged patients undergoing surgery to have the operation performed on a day chosen by the monks as auspicious for the patient, and he permitted the patients' relatives to camp in the hospital grounds so as to remove the patient's sense of isolation—there being no cultural precedent for the confining of a patient in an institution.

[29] OIOC, MSS Eur D979, Ludlow collection, Ludlow diary entry, 31 March 1926.
[30] See McKay forthcoming a.
[31] McKay forthcoming b.

Guthrie seems to have displayed, however, very little interest in the Tibetan medical system. Indeed, as far as I can ascertain, none of the Indian Medical Service (IMS) officers who served in Tibet devoted any serious attention to that system.[32] By the 1940s the uncomplicated faith in biomedicine that characterised the view of the Medical Officers in the early years of the century had faded somewhat, but it was only after the departure of the British that any biomedical practitioners developed an interest in Tibetan medical systems.

The British period in Tibet was nonetheless one in which significant numbers of people in central Tibet first became acquainted with biomedicine, and came to regard aspects of that system, such as vaccination against smallpox and cataract surgery, as elements of modernity which were plainly beneficial. With training in the biomedical system requiring the world-view imparted by a Western education, the medical modernisation process in Tibet could not have proceeded in the period under consideration. But the developments in Gyantse and Lhasa in this period do mark the beginning of the Tibetan encounter with state biomedical systems, and it is from this period that we may consider the question of interaction between the two systems.

The Situation in Indian Exile

When the Chinese took over Tibet in 1950, there were no qualified Tibetan biomedical practitioners and no biomedical public health system in Tibet. The British dispensaries were taken over by the new Indian government and subsequently handed over to the Chinese in 1954. In 1959 the Dalai Lama and around 100,000 of his people went into exile in India. The subsequent history of medical interaction within the Tibetan sphere of the PR China (i.e. TAR, and parts of Qinghai, Sichuan, Gansu and Yunnan provinces) contains many interesting parallels with the situation in the exile community, not least in regard to nationalist strategies and modernisation. But this subject has been prof-

[32] In contrast, early European medical practitioners in India drew heavily on local knowledge, and the general understanding that 'Indian' diseases were best treated by 'Indian' medical techniques persisted well into the 19th century. By the time of the encounter with Tibetan medicine, however, the British understanding of the 'scientific' nature of biomedicine, and its location within imperial ideologies of power meant that alternative systems to the biomedical were regarded as 'primitive' and unworthy of study by medical science.

itably explored by the work of scholars such as Craig Janes and Vincanne Adams[33] and my concern here is to trace the history of Tibetan medicine in exile, and to discuss aspects of its encounter with biomedicine in the ensuing decades.

Medical treatment for the exile community was originally provided by the biomedical facilities of the Indian public health system, soon supplemented by the attentions of Western aid agencies. But the Tibetans themselves soon began to actively restructure their community, which was centered around Dharamsala in the Himalayan foothills north of Delhi. In 1961, a Tibetan medical hospital, the Men-Tsee-Khang, was established there on land given by the Indian government. It was named after the Tibetan hospital in Lhasa, and in many cases staffed by veterans of that institute. Tibetan medical practitioners had already established a medical herb gathering operation centred around the Manali district of north-west India by that time, and it seems clear that the Men-Tsee-Khang began with the limited goal of providing the refugee community with its familiar medical treatment. But apparently to the Tibetans' surprise, they soon came to be called upon by Indians, the first of whom were high-ranking military officers from the Dharamsala cantonment. Some of these officers had served in Ladakh and were familiar with the local medical system there, and they consulted the Men-Tsee-Khang for conditions that had not been cured by their army biomedical physicians.[34]

In 1962 the Men-Tsee-Khang was given a favourable report following an Indian government enquiry and demand for its services continued to grow. In addition to the development of medical facilities in Tibetan refugee settlements, Tibetan medical clinics were subsequently established in most of the major cities of India with the support of large Indian companies such as Reliance, who contributed funds towards the clinics.[35] But the exile government also established a biomedical system for Tibetans in the refugee communities, and in 1971 the biomedical Delek Hospital also opened in Dharamsala, although this was originally a private hospital established with funding from a

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[33] See, for example, Janes 1999 and Adams 1998.

[34] Author interview with Dr. Lawang, retired Men-Tsee-Khang physician. Whether the Indian patients had previously tried Ayurvedic or other non-biomedical systems before resorting to Tibetan medicine is not known.

[35] *Ibid.*

Tibetan philanthropist and only came under exile government authority in 1979.[36]

The interaction of the Delek Hospital and the Men-Tsee-Khang today has not reached, though perhaps it aspires to, the situation that pertains in much of Bhutan, where local and biomedical treatment are available under the same roof. But Delek's director, Dr. Tsetan Dorji Sadutshang, is highly sympathetic to Tibetan medicine and has instituted an on-going education programme in which the Delek hosts speakers on Tibetan medicine and Tibetan medical practitioners train biomedical doctors in some indigenous practices. The stated aim of this is to orientate staff towards their own culture and to ensure patients feel comfortable in asking for treatment under either system.[37]

The initiative for meetings between the two sides has come mainly from the biomedical doctors and there is no formal structure of cooperation other than referral for notifiable diseases such as TB Otherwise this happens on a case-by-case basis. Biomedical staff may, however, refer patients to the Men-Tsee-Khang for such conditions as rheumatoid arthritis, hepatitis, certain types of dyspesias, mild to moderate neurosis and affective disorders, chronic pain and malignancies for which they consider Tibetan medicine efficacious.[38] Tibetan medical practitioners for their part recommend accident and emergency cases, and those requiring antibiotics or surgery to biomedical practitioners, and they have not hesitated to draw on aspects of biomedical practice such as taking blood pressure.

While biomedicine continues to be regarded at least from the point of view of the Tibetan exile government as foreign and not as embedded in Tibetan culture,[39] patients in the exile community today resort to treatment from both systems. Although both provide free consultations to the needy, and there are reduced prices for monks, nuns, and certain other groups, the cost of medicine may still be a factor. Given its acknowledged slow action, Tibetan medicine tends to be more expensive in the long term, so some patients do take up biomedicine because it is cheaper.[40] A week's course of antibiotics can be a lot cheaper than a year's course of Tibetan medicine.

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[36] Tsering 1996:1.

[37] Author interview with Dr. Tsetan Dorji, Director, Delek Hospital, May 2003.

[38] *Ibid.*

[39] Author interview with Kalon Lobsang Nyandak Zayul, Minister of Health and Finance, May 2003.

[40] Author interview with Dr. Marwari, Dharamsala, May 2003.

Patients may also, of course, be sent to the Indian state hospital system for certain advanced cases; the Dalai Lama for example, was apparently treated for pneumonia at an Indian military hospital. Patients may also consult a private practitioner, who may or may not charge them, and in the case of the only private biomedical practitioner in Dharamsala,[41] he estimates 80% of his patients are Tibetans.[42] Many, if not all, patients, however, have recourse to both systems in different instances and some patients of course take simultaneous treatment under both systems.

As is commonly noted elsewhere in studies of patients' recourse to so-called 'traditional' medical systems, patients' choice has a generational aspect. While the younger generation may take a positive view of Tibetan medicine in theory, due to its association with Tibetan identity, and there may be a growing interest and acceptance of the medicine of their traditional culture, their awareness level is not high,[43] and young Tibetans in India tend to have first recourse to biomedicine. Older patients, however, are often more comfortable with Tibetan medicine. The extent of an individual's identification with modernity is obviously a factor here, complicated perhaps by the large numbers of patients in Dharamsala who are recent arrivals from the Tibet Autonomous Region of the People's Republic of China. But all agree that Tibetan medicine takes time to effect its cures, and, as anyone who has been there recently will confirm, in Dharamsala today it is a fast-moving world where fast-acting medicine may be a more practical choice, not of a culture, but of individuals who situate themselves within the modern world.

NOTE

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[41] Simplification: actually McLeod Ganj, the Tibetan village above Dharamsala.
[42] Author interview with Dr. Marwari, May 2003.
[43] *Ibid.*

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INTEGRATING ABSTRACTION: MODERNISING MEDICINE AT LHASA'S MENTSIKHANG

VINCANNE ADAMS

INTRODUCTION

Working in the women's division of Lhasa's Tibetan Hospital, the so-called Mentsikhang (Sman rtsis khang), in the year 2000, I recorded the following conversation. It occurred in the context of research with two doctors (one was a doctor of Tibetan medicine and director of the Women's Division and the other was a biomedically trained Tibetan physician who worked in the ward whose parents were both doctors of Tibetan medicine). I had been trying to explain that our research project, observing the outcomes of using Tibetan medicines for treatment of growths in the uterus and ovaries, would be difficult to do now that it had become standard operating procedure to treat all of the inpatients with antibiotics upon their admission to the hospital. "I won't be able to tell what is a result of using the Tibetan medicines and what is a result of using the antibiotics", I told them. They reflected on the problem and finally the director told me: "But this is integrated medicine", referring to the fact that in many wards of the Mentsikhang policies to 'integrate' Tibetan and biomedicine had been implemented for many years now.

My concerns over how to evaluate one medicine over the other were quickly set aside when, seeing my point, they nevertheless offered to withhold antibiotic treatments from the poorest patients, forming a comparative cohort, they said, since those patients would have a difficult time paying for the antibiotics anyway. Everyone knew that Western medicines cost up to ten times the price of Tibetan medicines and the hospital had a hard time justifying subsidising these medicines for poor patients. I told them that while I appreciated their flexibility, I didn't have permission to do that sort of study, and that dividing cohorts along class lines would, at any rate, introduce an unwanted variable, aside from it being questionable from the ethical perspective favoured by my own university.

'Integrated medicine' as I came to observe it in practice in the wards of the Lhasa Mentsikhang was a collection of efforts unevenly woven together to treat and heal Tibetan patients within the context of overwhelming pressures to modernise in specific ways. At times, this required doctors to work within scientific, financial, and political constraints. The fact that my colleagues were trying to figure out how to accommodate my research interests that would require them to isolate their treatment programmes by single medical interventions marks the first of these constraints. That their solution was to work within a structure characterised by growing financial disparities and decreasing hospital resources maps the second of these. What was left unstated was the fact that these suggestions were offered in the context of a growing set of political concerns that, ironically, aimed to depoliticise all medical practice and research and in doing so, place limits on what could and could not be done, said, and proposed in this context. Collectively, these constraints (and others) can be mapped for their cumulative effects. In this paper, I suggest that one of these effects is that integration occurs by way of a prioritising of, and preference for, biomedical techniques and practices over those of Tibetan medicine that leaves Tibetan medicine appearing 'abstract'. That is, the complex set of practices called 'integration' makes aspects of Tibetan medicine appear abstract in contrast to the biomedical options that are frequently used as the yardstick by which to modernise in this context. I call this process 'integrating abstraction', in which abstraction has the meanings of being, in different contexts and in relation to different aspects of Tibetan medicine, 'less concrete', clinically and theoretically 'chaotic or disorganised', 'extraneous' to the real basis of medical efficacy, 'vague', and simply 'unscientific'. In the end, under these influences and constraints, Tibetan medicine becomes marginalised, even while lip-service is paid to the idea of its preservation.

Before this, however, a few disclaimers are needed: I do not take the history of Tibetan medicine (henceforth TM) as one of stable uniformity—in the sense of an invariable or unchanging tradition—until arrival of modernisation. Rather, TM has been, from its very inception, an integrative medicine, incorporating elements of a wide variety of historical healing practices (Meyer 1988; Dummer 1988). Second, exposure to biomedicine did not begin with the arrival of Chinese socialism in Tibet. On the contrary, exposure to biomedicine began early on at the turn of the century, by way of British stations in Tibet, and by way of

Tibetan missions in India (McKay, this volume, and 1997; Adams 2000). Moreover, Tibetan efforts to radically modernise their medical system can also be traced to the first decades of the 20th century, with the building of Mentsikhang as an institution designed to resemble secular institutions of higher education in the West. However, the influences of modernisation and the integration I am concerned with in this essay are limited to those emerging over the last fifty years of exposure to biomedicine by way of Chinese socialism and, later, foreign health development efforts. Also, I note that many of the insights presented here are relevant to Lhasa and other urban branches of Mentsikhang and not necessarily relevant to the larger set of practices of Tibetan medicine outside of the TAR. Finally, although biomedicine itself does not form a unitary or uniform set of practices or theory, and certainly varies considerably in form and content when viewed across national and geographic boundaries (sometimes with little similarity to biomedicine seen in places like the United States or Europe, Berg and Mol 1998), I use the term here as a way of demarcating that set of practices officially recognised by the Chinese state and called by Tibetans *phyi lugs sman*, 'outside medicine', or *rgya sman*, 'Chinese medicine', or *tang sman*, 'Party medicine' or *xi yao*, 'Chinese medicine' (using Mandarin).[1]

For the purposes of this presentation, I have grouped the trends that are having the most visible impact on practices and theory in TM under 1) depoliticisation and secularisation and 2) commercialisation. Again, these trends are not merely the product of aggressive governmental policies aimed at modernisation hoping to eliminate many of the disparities between the TAR and other regions of the PRC. They are also the result of international engagements that have rapidly grown both inside and outside the TAR in the fields of medicine, research, marketing and society more generally over the last decade.[2]

[1] Above all, it has been Tibetan medical scholars and practitioners' exposure to these biomedical practices (mediated by the state) that has had an impact on the practice and theorising of Tibetan medicine today, and this impact is mediated by scientific, financial and political concerns.

[2] The data in this paper were collected over the years from 1993 to 2003, on several different projects focused mostly on the women's division at the Lhasa Mentsikhang. The latest project involves collaboration with a team of US physicians, nurses and fellow anthropologists. Various non-Tibetan resident persons with whom I have conducted research or who have collaborated on other projects which indirectly provided these insights include: Dechen Tsering, and Kalsang Yangdron, Sienna Craig, Fei Fei Li, Suellen Miller (PhD), Arlene Samen (RN), Michael Varner (MD).

Depoliticisation and Secularisation

Depoliticisation is tied to secularisation and refers to the ways in which exigencies of political discourse in contemporary TAR require that one show diligently that one's work is essentially apolitical, in both clinical practice and theory-making. Historically speaking, this is new. From the 1950s, and surely before that time as well, politicisation was required of medical professionals throughout China (Farquhar 1994; Janes 1995, 1999, 2001). This meant ensuring that one's medical practices were supportive of and in keeping with mandated government political objectives. During the 1960s and 70s, for example, Mentsikhang physicians participated in public health campaigns designed to treat the masses, including training in barefoot doctor techniques, serving the rural proletariat for many years, and deploying a rhetoric of support for traditional medicines, and even revising traditional medical theory, to show its consistency with Maoist agendas.

Today, in contrast, the emphasis is to depoliticise, that is, to show that one's work and speech are not political. This is not to say that government agendas are not visible in medical institutions. On the contrary, the government spends enormous time and money on political training (medical students and staff, for example, still must attend weekly meetings where government political agendas are laid out). Rather, it is that today one must be vigilant to show that one's medical practices do not make one vulnerable to accusations of being unpatriotic. This is in part a result of the way the colloquial use of the term 'politics' no longer means 'support for the revolutionary cause' but rather a problematic set of concerns tied to 'splittism'. Thus, to be 'political' now, it is presumed, is to harbour dissent to the current regime. To be acquiescent to government agendas is to be 'apolitical'.

Of course, the overwhelming focus of the government's political fear is on religion. The government, even while contributing to the preservation and support of religion, still perceives political resistance as tied first and foremost to religious sites and persons, partly because of exile-based efforts and partly because of internal policies that have historically been harsher on religious persons than other laypersons. Thus, in medicine, this perception translates into several things: an unstated mandate (which is variously adhered to by different kinds of practitioners) to show that Tibetan medicine is 1) not religious, and 2) that most of the concepts and practices can be thought of as apolitical in the same

way that biomedicine considers itself apolitical because it is 'scientific'. These demands result in an overall effort found within Lhasa, at least, (again, not without exceptions) to secularise Tibetan medicine by way of a language of 'science'.

At the same time, secularisation has spawned internal debates over what actually constitutes 'science' (*tshan rig*). Again, this can be explored historically. During the Cultural Revolution, materialist secularism was taken as 'scientific' and in medicine this meant removing reference to folk beliefs, mention of spirits, concepts that were clearly Buddhist from the practice and writing about Tibetan medicine. Tibetan medicine was stripped down to a set of named disorders with discrete prescriptions for cures, discarding theory as elitist. In this context, being 'scientific' meant being pragmatic and clinically-oriented rather than theory-oriented. A whole generation of Tibetan practitioners was trained with little knowledge of theory and, today, some Tibetan doctors worry about the effects this lack of knowledge will have on their institution.

Now, Tibetan medical students enjoy renewed efforts to teach theory, but this still means avoiding overt reference to religion and establishing these theories as 'scientific'. 'Science' has become a placeholder for all that stands in opposition to politics. Thus, discussion of the five elements, the karmic basis of the humours, conception and foetal development, and even fairly complex ideas about the relationship between consciousness, humoral capacity, and spirituality are being debated in terms of their scientific bases, or lack thereof, in order to avoid labeling them as 'religious'. In this effort, some scholars take biomedicine as the universal model for what constitutes a 'scientific' approach in medicine, and the legitimacy of Tibetan concepts is gauged in terms of its ability to match the biomedical (Adams 2001, 2002). For others, Tibetan concepts are identified as 'scientific' in their own right, and therefore should be seen as models of physiology, anatomy and so on that are alternative to biomedicine.

Often, these debates revolve around the idea that a truly scientific medicine would be able to show tangible evidence of its anatomical and physiological claims—a position shared by Tibetan and foreign scholars. In this context, Tibetan medicine is seen as anatomically abstract because many of its constructs are not visible upon anatomical dissection, and physiologically abstract because its theories of function require conceptual leaps between things like the organs, humours and

the elements. The elements are not measurable or tangible in the same ways that say, biochemical processes can be measured and assayed. Tibetan models are thus identified as 'less concrete' than biomedical concepts. In order to make them appear more concrete, biomedical terminologies are often adopted as translations of Tibetan ideas. *Rtsa gsum* become uniformly 'nerves, veins and arteries' rather than the more general 'channels' along which flow a variety of forces or energies that do sometimes more or different things than, say, nerves, veins or arteries. Disorders arising from 'demons' or 'spirit causes' which are still found in texts are now translated as symptoms of known biomedical diseases, from epilepsy to tuberculosis and cancer. Disorders that identify a systemic and humoral disruption of physiology and resulting in a syndrome-like condition (that links multiple organ systems to humoral function by way of 'invisible' energies) are renamed as specific physiological disorders tied to a single organ, such as when *mngal nad ti gyur* (bile-related womb disorder) gets translated as "pelvic inflammatory disease" thus effacing complex theories about the linkages between organ systems and humoral robustness. Or again, the terminology of biomedical psychology and psychiatry is substituted for a variety of disorders that are related to wind imbalance, without recognising that neither Western-based psychiatric or psychological languages can encompass the range of meanings tied to the concept or function of winds. The most frequently seen version of this is when wind (*rlung*) disorders are translated as 'anxiety disorders' or 'depression' with reference to biochemical imbalances.[3]

Not all scholars of Tibetan medicine follow this approach and there is debate over how to correctly translate many of these terminologies and concepts. At the same time, one can find efforts to eliminate concepts that are considered too abstract because they have no biomedical equivalent and are therefore seen as extraneous. Theories of fetal development, for example, are discussed in terms of neuroanatomy while the role of karma and consciousness is left out.[4] It is sometimes assumed

[3] I am not suggesting that this means that Tibetan patients no longer seek religious or spirit-based healing, only that within the context of the medical institutions, these types of treatments are seen as more and more marginal to officially-recognised Tibetan medicine, at least in urban TAR locations.

[4] Just as there are debates over what constitutes 'scientific' in medical practices and theory, there is also much debate over what constitutes 'religion' in the medical context, since the Tibetan language did not really distinguish between fields of knowledge that were so labeled. In numerous contexts at the Medical College, at Mentsikhang, and at the pharmaceutical factories, these debates become visible.

that losing these pieces of Tibetan medical theory does not necessarily undermine the integrity of the practice.

Similarly, efforts to conduct clinical research with foreigners sometimes can have the effect of making Tibetan medicine appear abstract in the sense of it appearing unscientific in the eyes of foreign researchers, and eventually in the eyes of Tibetan doctors as well. For example, efforts to locate single medicinal recipes for standardising medicines for use in a clinical study are sometimes thwarted by the fact that different institutions and different practitioners might use slightly different recipes for the same medicines, or by the fact that the source of ingredients used in these recipes is considered more or less potent than that used by others. Techniques for deciphering potency are integral to a more traditional Tibetan approach to medicine—and a means of distinguishing high quality practitioners from lesser qualified—but are seen by foreigners as evidence of a kind of randomness or chaos within Tibetan medicine because there is a lack of uniformity and standardisation of medicines. Rather than make the case for the benefits of a 'specific intellectual' approach in medicine, Tibetan doctors are more likely to try to develop a way to standardise their medicines according to biomedical techniques (even when this means processing ingredients in ways that compromise the potency of ingredients, discussed below).

Today, medical researchers and clinicians are confronted with new models for research that are based on the standard of the biomedical clinical trial which, again, is taken as a more precise model for evaluating medical efficacy than what has happened historically in Tibetan medicine (the emphasis has historically been on developing new medicinal recipes and treatment research was more of a trial and error approach involving single clinicians with no complex statistical analysis). The biomedical approach tends to offer reductionistic protocols (testing single medicines at a time) and takes as its starting point for evaluating efficacy biomedically named diseases and biomedical diagnostic measures. The fact that a single biomedically named disease might be seen as having a variety of different causes in different individuals (bile-related versus wind-related, for example) and therefore different treatment regimens, appears to foreign researchers as something that poses a threat to a scientific protocol that insists on measuring the effects of single medicines at a time and lumping these patients together in similar testable cohorts.[5] In general, this approach puts

Tibetan medicine at a disadvantage and not infrequently results in failure to show effectiveness of the Tibetan medicine. The net result is often loss of faith in Tibetan medicines on the part of Tibetan practitioners.[6]

Perhaps the most serious impact of a secularisation that uses biomedical techniques as the standard for an 'apolitical' and scientific medicine is a routinisation of medical practices in ways that foreground biomedical knowledge. Mentsikhang, for example, is told by the Health Bureau that it must follow conventions of scientific medical practice, including record-keeping, standard treatment protocols, and diagnostic measures. So, doctors of Tibetan medicine are increasingly forced to produce information about patients that use biomedical technologies (ultrasound reports, blood tests, urine tests, X-rays, and so on). Records of patients are produced using the models found in the biomedical hospitals (from admission through treatment and discharge) and these include required reporting of basic biomedical measures of symptoms. Departments within Mentsikhang are regularly visited by health bureau officials to make sure that such record-keeping is carried out, and fines can be incurred by the hospital if records are not in order. In this context, the traditional practices of Tibetan medicine that favored individualised diagnostic and therapeutic regimes over record-keeping and standardising of treatments appear abstract because they look chaotic and unmanageable from the perspective of a government concerned with recording statistics on the health of its population, and the patient populations of Mentsikhang. Because the information from Mentsikhang needs to be grouped together with information from the large number of biomedical hospitals in cities like Lhasa, the default mode is to have Mentsikhang use biomedical categories rather than trying to make the difficult translation between diagnostic systems at the extra-clinical level. Sometimes even pulse diagnosis and Tibetan names for disorders are not seen in records at Mentsikhang. Using biomedical

[5] There are some 'observation'-based clinical research models that focus only on 'outcomes' which can accommodate multiple forms of therapy in comparison with a single biomedical treatment, but these studies are usually seen as preliminary to more acceptable and reliable randomised controlled clinical trials that focus on single treatment modalities.

[6] The example of *Helicobactor pylori* research done by Fei Fei Li (see Adams and Li 2007), is a good indicator of how this happens. Although the Tibetan treatments eliminated all symptoms associated with HP infection, the fact that they did not eliminate HP bacteria was used by Tibetan physicians as a sign that the Tibetan treatments were not useful.

standards for record-keeping and diagnosing gives the appearance of uniformity to hospital wards that have traditionally lacked a need for statistical data analysis about their patient populations. This, too, might be seen as a result of 'scientisation' in the sense that Foucault identified the leap to modernity as arising from the ability of a new 'scientia' of biopolitics to harness and account for health at the level of not just individuals but entire populations (Foucault 1981).

More interesting is that use of these biomedical measures is seen by many Tibetan doctors as easier than Tibetan methods for pinpointing diagnoses. Thus, for some Tibetan doctors, the biomedical techniques become a shorthand way of classifying and diagnosing patients. Again, they are seen as providing more immediate and concrete facts about the patient's health than the difficult and sometimes arduous route of pulse, urine, tongue or questioning for diagnosis, which can take years to perfect. Tibetan techniques appear vague and arduous in relation to biomedical techniques, despite the fact that experienced practitioners will attest to a much more robust specificity using Tibetan techniques properly and with expertise. In the end, however, use of these biomedical diagnostic measures is growing. This trend has the potential to entirely efface use of traditional Tibetan diagnostic measures. Once the diagnostic measures from biomedicine are used, physicians frequently also deploy the biomedical disease names (in Chinese) for their patients conditions. It is even sometimes assumed that one disease named in biomedicine is substitutable for a Tibetan disorder but this simple translation actually eliminates the possibility of reading the Tibetan disorder in terms of its 'difference' from the biomedical condition, in relation to both humoral proximate causes and other ultimate causes of the disorder.[7]

In sum, the combined needs for depoliticisation, secularisation and 'scientisation' of Tibetan medicine, in the Lhasa context, are both opening new debates about the meaning of science and religion in relation to traditional Tibetan medicine, but also in a practical sense already producing important changes in the way Tibetan medicine is actually delivered and theorized in its premier government-recognised

[7] See Adams 2002, for more specific cases of this. The problem is that for many Tibetan-named conditions there is not one single biomedical disease. Most often, one Tibetan disease can translate into several biomedical diseases and *vice-versa*. Sometimes in order for practitioners to make these diagnostic leaps, they must focus on a narrow set of symptoms, and they must ignore causative models (a point also made by Eric Jacobson).

urban-based institutions. In large part, I believe these influences run the risk of marginalising Tibetan medical knowledge and practices because they are increasingly seen as abstract and unmanageable in contrast with biomedical concepts, practices and research techniques which are increasingly taken as the template for good 'science' in this locale.

COMMERCIALISATION

Commercialization refers to the outcome of liberal market reforms since the 1980s that have placed increasing emphasis on valorising only those aspects of Tibetan medicine that can bring financial profits. This trend is a result of both desires on the part of administrators to gain profits for themselves and their institutions and a result of forced privatisation in which decreased government subsidies resulted in increased burdens of medical institutions to become self-sufficient. Here too, one can see the problems arising from a perceived need to 'integrate abstraction'.

In one sense these trends of commercialisation crosscut those of secularization when, for example, Tibetan pharmaceutical producers learn that some of the medicines they produce actually sell more widely and prolifically throughout China because they are perceived by consumers (Tibetans and inland Chinese ethnic groups—including Han—alike) as having special healing powers because they have been blessed by skilled lamas (or are believed to have been) in ceremonies of *sman grub*.[8] But in other respects, the trend toward commercialising Tibetan medicines and producing them for a mass market also fuels a secularisation of their production and a host of problems regarding ownership and competition articulated around perceptions of the 'abstract' qualities of Tibetan medicine.

For example, mass marketing of medicines throughout China has meant introducing production practices that some say compromises their potency. Specifically, some say that potent ingredients are no longer available because they have been overcultivated and subjected to homogenisation processing requirements that undermine the elemental composition of the ingredients.

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[8] For example, the rush for purchasing Tibetan medicines during the SARS outbreak of 2003 is a case in point.

A good example of this is the effort to homogenise ingredients at the Tibetan Medicine Pharmaceutical Factory (under the auspices of Lhasa Mentsikhang) by way of boiling and heating all the ingredients rather than cold grinding and mixing to preserve their own elemental thermal properties. Some practitioner-scholars argue that heating the ingredients in this way compromises the elemental heat (from fire) and cold (from water) qualities of the ingredients, while others adopt a more biomedical view that biochemical potencies will not be harmed by the external heating process. Whereas protecting the elemental composition of ingredients is a priority for Tibetan medicine, standardising and homogenising ingredients is more important for meeting biomedical production standards adopted by the state. The latter make the traditional methods of production seem random, in that ingredients can vary in potency from batch to batch and single pills can vary in composition within a batch. To rectify this, efforts are being made to standardise in ways that ignore the debates about elemental potencies and composition. Even here, theories about elements appear abstract in contrast to those of biochemistry.

More importantly, some say that mass commercialisation has led to the need to train pharmacists who specialise in producing medicines but know nothing about clinical practice or theory, especially theory that comes from more religiously-oriented experts. Doctors don't learn enough about how to compound their medicines, and compounders don't know enough about how to practise medicine. This too can be read in terms of the ways that historical practices are made to appear chaotic, when placed in comparison with the tendency toward specialization within clinical versus pharmaceutical fields as seen in biomedicine. Doctors who train fully in compounding are seen as not being concrete or knowledgeable enough in their area of expertise.

More significantly, the training of practitioners who can meet new production demands for Tibetan medicine can result in the elimination of certain kinds of expertise that is made to appear extraneous to Tibetan medicine (because it can't be scientifically verified). Reference to actual religious practices that occur within the context of the production of medicines (such as the consecration of medicine through *sman grub*) or the clinical encounter (allowing lamas or monks into the clinical setting on patients' behalf) are problematic because they are seen as both politically dangerous and also recklessly unscientific. This is true, despite the sometimes overwhelming pan-China public desire for

things like 'precious pills' which have been blessed, or clinical consultations with lamas and monks (a point to which I return below). The fact that such blessings do occur both within the Mentsikhang and in various monasteries near Lhasa,[9] does not mean that they are not perceived as politically problematic at certain times. More importantly, such practices are seen by some (though not all) scholars and medical officials as abstract in the sense that they are labeled as extraneous to the real scientific underpinnings of Tibetan medicine rather than intrinsic. In some cases, this means that they are treated as if they could be discarded without affecting the efficacy of the practices. In other cases, the blessing/consecration is seen as important but in the sense of a kind of packaging for marketability, rather than fundamental to the potency of the ingredients.

That pharmaceutical companies are finding a market for some Tibetan medicines outside Tibet has also meant that some medicines are no longer produced by the factory on grounds that there is no profitability in producing them. This leaves some clinical departments in a rut, when the medicines they need for a small cohort of patients are unavailable. Although departments that have Tibetan physicians who were trained in collecting and compounding ingredients and who can make their own medicines, other departments are left without important medicinal resources for their patients. Even in those departments that can produce their own medicines, the expense is often prohibitive. Thus one effect of the mass production of Tibetan Medicines is that even though historically the production of medicines was very location —and lineage-specific (a situation that could be called specific and definitive), it is now made to seem more chaotic than ever, with different sites for manufacturing the same medicines, different availability of medicines at different locations, and an unpredictable production schedule that makes availability of medicines seem random. In contrast to supplies of biomedicines, the Tibetan medical pharmaceutical picture looks abstract and confusing.

Finally, that there is a growing commercial market for Tibetan medicines has meant increasing competition between the medical college, the Mentsikhang and the pharmaceutical factories over recipes and claims about potency for the same-named concoctions. Some of these institutions are state owned, while others are joint private ventures

[9] See the work of Frances Garrett at the THDL website (www.thdl.org).

between Lhasa-based medical entrepreneurs and Chinese pharmaceutical businesses. In this competition, Mentsikhang and the medical college (both state institutions) are at a distinct disadvantage for being able to mass market, but occasionally claim to have the more potent recipes and therefore the most potent medicines. Once again, this gives the appearance of competitive chaos to the production of Tibetan medicines, when it becomes more and more visible that different institutions of Tibetan medicine debate the terms by which 'quality' of medicines will be determined.

Medical departments at Mentsikhang and the medical college are trying to commercialise their own medicines as a result of other financial trends. Liberal reforms eliminating government subsidies for hospitals have had a huge impact on clinical practice. Up until recently, medical expenses for those working in government work units were paid by the government. Now, however, work units can opt to provide or not provide medical insurance to their workers. In some cases, work units will cover up to a certain percentage of medical costs. In rural areas, insurance plans that require villagers to pay an annual health service fee is being used to pay for rural health care. As a result of these trends today, large numbers of Tibetans are not covered for their medical expenses and this leaves hospitals in the position of having to come up with new ways of getting paid for their services.

At Mentsikhang, each department has had to increase the amount that patients are charged for their care, including tests and medicines, beds and food. Some departments are even planning to offer different levels of accommodation (private rooms with televisions and meals cost more than the dormitory style room without meals). Departments must also occasionally make triage decisions for treatment on the basis of what they feel their patients can or cannot afford. As I learned in my own efforts to conduct clinical research, this sometimes translates into a hierarchical treatment pattern, in which the wealthiest patients get the most complete and exclusive forms of care, while the poorest patients get the least complete and least exclusive care, sometimes being treated purely on an outpatient basis despite clinicians' preference to have them as inpatients. The impact of these market reforms gives an even more complex appearance to Tibetan medicine, with different departments within Mentsikhang setting different policies on how they will recoup expenses, and prioritising income strategies over efforts to create triage practices on the basis of severity of disease, type of disease,

or type of treatments.

In summary, commercialisation has not always led to an effacing of practices or theories of Tibetan medicine in the same ways that politicisation and secularisation have. In fact, sometimes commercial concerns have the opposite effect and efforts to bolster recognition of Tibetan medicine's religious background are fostered. But, given the overall climate within which Tibetan medicine is being practised today, this effort is greatly compromised. As more and more Tibetan scholars and clinicians embrace the possibility of modernising their tradition, they increasingly confront dilemmas as to what to do with traditional knowledge. More often than not, this knowledge is seen as highly complex and difficult to both learn and teach because it appears more complex, more chaotic, more abstract, and sometimes more random that the perceived practices of biomedicine in this locale. Whether or not it is accurate, the perception widely held among progressive Tibetans is that techniques of biomedicine and its theories are easier to teach and to grasp because they are more uniform, and more concrete. When they can be inserted as easy substitutes for traditional concepts, they are. Where traditional concepts appear too abstract, and knowledge of how they actually explain things like disorders (that is, how the humors are affected by the elements and how they in turn disrupt organ or system function) appears too complex, it is sometimes simply that such information is just dropped altogether.

Coupled with the tacit assumption held by many officials in the Health Bureau that biomedicine's efficacy is a given, while Tibetan medicine's efficacy must be constantly proven (over and over again), commercialisation incentives lead to a further marginalising of Tibetan medicine. Efforts to prove Tibetan medicine invariably look to biomedical models of efficacy, research, and ultimately commercialisation. In order to prove that Tibetan medicines work, they have to be refigured in the form of, and used in ways that are comparable with, biomedicines. The legal requirements are set by the Chinese state, and Tibetans are eager to meet these requirements so that they can sell their medicines elsewhere and reap the financial rewards. But, to register these medicine with the government in order to recoup profits from their sale, Mentsikhang must undertake this elaborate process of 'fitting' its approach to medicine (and to patients) into biomedical models. In the end, it will be interesting to see how the scholars and clinicians of Tibetan medicine are able to negotiate the turn toward modernisation,

and to see what the Tibetan medicine of the future will look like.

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SA CHA 'DI MA 'PHROD NA... DISPLACEMENT AND TRADITIONAL TIBETAN MEDICINE AMONG TIBETAN REFUGEES IN INDIA

AUDREY PROST

This chapter attends to contemporary developments in exile Tibetan medicine and conceptions of health. In particular, it focuses on the role of the Dharamsala Men-Tsee-Khang and Tibetan medicine in addressing problems of public health in the Tibetan exile community.[1] In the first part of this article I explore the significance of the re-emergence of the traditional Tibetan medical concepts *'bu* and *srin bu* ('germs' and 'parasites')[2] in the exile context. Germane to this discussion is the idea that certain concepts in classical Tibetan medicine[3] are now being given new salience because of their compatibility with biomedical concepts.[4] In the second part, I examine the notion that many prevalent exile diseases are construed as diseases of place: they are seen as resulting from the physical, social and moral predicaments of exile. This leads on to the argument that traditional Tibetan medicine is particularly apt at dealing with what could be called 'diseases of exile' because of its emphasis on localistic aetiologies,[5] aetiologies that link diseases

[1] Here I use the concept of 'public health' in the broadest possible sense, not as an aggregation of health indicators such as mortality or morbidity rates, but rather, and closer perhaps to its Tibetan understanding, as inherently socially defined and produced. The interaction between traditional Tibetan medicine and biomedicine in exile in Dharamsala is far too vast and complex a topic to be tackled here, and this chapter focuses principally on traditional Tibetan medicine as practised by the Dharamsala Men-Tsee-Khang.

[2] In translations of the *Rgyud bzhi* headings, Men-Tsee-Khang doctors gloss *'bu* as micro-organism and *srin bu* as parasite, although further exploration of the popular use of these terms reveal that they have more complex meanings. The compound *'bu srin* is also sometimes used to designate insects or worms. Specific species of parasites are designated by adding compound syllables to *srin bu*, eg. *srin bu kwa* (maggots), or *srin bu mchu ring* (mosquito).

[3] Inasmuch as such a label may be considered valid. In this context it refers to the theory and practice of Tibetan medicine as outlined in *Rgyud bzhi*.

[4] On this topic, particularly the emergence of diabetes (*di ya bi tis*), see Gerke 1998.

[5] These are aetiologies that relate bodily states to place-specific environmental factors, especially climactic and seasonal changes. Such a localistic approach is discussed by Paul Unschuld (1985) in reference to Chinese medicine.

to organisms or spirits pertaining to particular places. This ability to offer means for the identification and treatment of diseases of exile is, I argue, at the core of the Men-Tsee-Khang's success as a healthcare provider in the community.

Complex Aetiologies and the Politics of Contemporary Exile Tibetan Medicine

From October 2000 to September 2001 I attempted to research and map out local understandings of health in the exile community of Dharamsala (H.P., India). This meant tracing the therapeutic trajectories of patients between traditional and biomedical care, for diseases ranging from *rlung* (wind) disorders to tuberculosis (TB). It also meant finding out how the social context of exile had affected the theory and practice of both traditional Tibetan medicine and biomedicine as practised in the local hospital. With this aim I interviewed patients and doctors both in the local biomedical hospital, i.e. the Delek Hospital (Bde legs sman khang), and at the Men-Tsee-Khang in Dharamsala.[6] Many of these conversations revealed anxiety related to the spread of 'infectious diseases' both in the biomedical sense, as with TB—and in the popular sense, denoting a concern with contamination generally speaking.

In both biomedical and traditional settings, practitioners and patients commonly mixed references to parasites and bacteria with more religiously orientated explanations, mostly references to *las* (karma), and, albeit more rarely, to *gdon* ('demons'). The following table shows the results of a survey about prevalent diseases compiled through interviews with 36 patients visiting the Men-Tsee-Khang and 38 patients from Delek Hospital, in which the patients were asked what caused prevalent diseases.[7]

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[6] The patients were not interviewed after clinical consultations at either institutions, so as to avoid reiteration of the doctor's diagnosis. Each patient interviewed was asked about explanations for the whole set of disorders, not simply of the one's which they had experienced.

[7] The format of this table was deliberately chosen to enable comparisons with a similar survey conducted by Geoffrey Samuel (2001) in Dalhousie.

Disorder Category	Causes (English)	Causes (Tibetan)	N.M TK	N. Delek
drod khog bshal ba (*diarrhoea*)	Unclean water *'bu* (insect/bacteria) Rotten/bad foods	*chu btsog pa* *'bu* *kha lhag rul ba*	22 17 16	26 34 11
chi nyi [chinni] na tsha (most often translated as diabetes)	Fatty/oily foods Over-eating *mkhris pa* 'disorder' Heredity (descent) Karma (past actions)	*kha lhag snum pa* *lhag thal za ba* *mkhris pa* *gdung rgyud* *las*	32 31 29 13 5	25 30 22 25 7
ti bi na tsha (TB)	Infectious *'bu* Isolation with other TB patients/ contagion Irregular/insufficient eating Karma (past actions)	*'go ba'i 'bu* *ti bi nad pa mnyam du sdod pa/ 'go nad* *bcud med zas spyad* *las*	33 26 26 10	38 24 11 6
chams pa (cold)	Cold climate (Being in) cold and damp places Contagion from family or neighbours	*gnam gshis grang mo* *sa cha grang mo dang bzha' tshan nang mi* *khyim mtshes 'go nad rgyab pa*	34 35 8	37 32 22
grum bu'i na tsha (arthritis, rheumatism)	Being in cold and damp places Cold foods Heat and cold disorder Karma (past actions)	*sa cha grang mo dang bzha' tshan sdod* *kha lhag grang mo* *grang ba dang tsha ba la sogs pa'i sdug bsngal* *las*	31 30 16 18	27 23 9 12
mdze nad (leprosy)	Living in poor, bad conditions Karma Lepers The condition of having *chu ser nag po / mkhris pa*	*dbul po, sdug cha sdod tshul du* *las* *mdze nad pa* *chu ser nag po dang mkhris pa*	27 13 10 6	34 14 18 3
kan ser (Cancer)	Heredity Change in food habits Changing from habitual place and climate Old age Karma	*pha ma rgyud / gdung rgyud* *zas lugs srol rgyur* *sa cha dang gnam gshis gyur* *rgas ka* *las*	2 7 17 29 5	9 11 21 23 3
khrag shed (high blood pressure)	Salty and rich foods Heredity Alcohol	*kha lhag snum pa* *pha ma rgyud / gdung rgyud* *chang / a rag*	32 15 22	38 16 25

Disorder Category	Causes (English)	Causes (Tibetan)	N. MTK	N. Delek
mgo nad (*headaches*)	*mkhris pa* imbalance	*mkhris pa*	27	11
	Hot climate, being under the sun	*gnam gshis tsha po, nyi ma 'og sdod*	30	26
	Use of alcohol or strong tea	*chang, a rag, ja gar po 'thung ba*	25	22
	'Heart' *rlung* imbalance	*snying rlung*	12	17
	Demon/ spirit influence	*gdon*	4	8
pho ba'i na tsha (*stomach problem*)	Cold foods	*kha lhag grang mo*	21	10
	Unclean foods	*kha lhag ma gtsang*	30	32
	Unclean water	*chu btsog pa*	35	33
	Hot or spicy food	*kha lhag tsha po, skyur po za ba*	13	8
mkhal nad (*kidney problem*)	Cold climate	*gnam gshis grang mo*	29	25
	bad kan / rlung disorder	*bad kan / rlung*	20	17
	rlung / mkhris pa disorder	*rlung / mkhris pa*	14	2
	Sweet foods	*kha lhag mngar mo*	13	6
	Alcohol	*chang, a rag*	10	2
	Cold foods	*kha lhag grang mo*	14	9
snying gi na tsha (*heart problem*)	*rlung*	*rlung*	12	13
	Fatty foods	*kha lhag snum pa*	30	26
	High Blood Pressure	*khrag shed*	31	30
mchin nad (*liver problem*)	Fatty foods	*kha lhag snum pa*	25	16
	'Brown bad kan'	*bad kan smug po*	21	20
	Hot spicy foods	*kha lhag tsha po*	26	20
	mkhris pa disorder	*mkhris pa*	19	17
	Alcohol	*chang, a rag*	30	32
	Hepatitis	*hepatitis*	13	24
rlung gi na tsha (*wind disorder*)	Worry, anxiety	*sems khral byed pa*	25	30
	Financial problems	*dngul gyi rnyog khra / sems khral*	31	32
	Sadness	*skyo ngal ba*	23	18
	Family problems	*bza' tsang rtsod pa / rnyog khra*	14	19
	Changing from 'hot' to 'cold' place	*sa cha tsha ba nas bsil bar gyur*	15	19
	Unbalanced activity levels, unhappy life	*tshe tsul ma snyoms, tshe tsul ma skyid*	18	22
	Demon, spirit influence	*gdon*	6	3
mkhris pa'i na tsha (*bile disorder*)	Hot climate	*gnam gshis tsha po*	15	4
	Hot foods	*kha lhag tsha po*	18	13
	Fatty foods	*kha lhag snum pa*	22	20

Disorder Category	Causes (English)	Causes (Tibetan)	N. MTK	N. Delek
glo'i na tsha	Dirty air (pollution,	*rlung btsog pa*	30	34
(lung problems)	esp. car pollution)		7	4
	rlung	*rlung*	28	31
	Smoking	*tha mag 'then pa*	5	11
	Taking snuff powder	*sna thag 'thung*		
	Incense burning	*bsang gsur*	6	1

Table 1: Explanations for Prevalent Disorders

The ascription of particular diseases to plural aetiologies resulted in the production of complex causal narratives. For instance, I was told by TB sufferers in the biomedical Delek Hospital that tuberculosis was caused by a 'bacillus', described as a *'bu*, which then caused imbalances in the three humours (*nyes pa gsum*) and all the biomedically defined symptoms associated with TB.

One such example of aetiological eclecticism is the story of a civil servant from Gangkyi who reported suffering from chronic stomach pains for approximately 18 months. He had taken Tibetan medicine during that period but had noticed little improvement to his condition. He then went to the hospital to have a stool sample analysed, and took the course of antibiotics prescribed to him. He explained that he thought the condition had been caused by *srin bu* (which he translated as 'parasites' or 'germs'). When prompted further, he added that the *srin bu* had come because of a humoral imbalance, and that this imbalance was due to karma. This meant that a comprehensive treatment for this condition would involve three therapeutic layers: biomedical treatment to get rid of the *srin bu*, Tibetan medicine to correct the imbalance, and finally a series of prescribed rituals or recitations to annul the bad karma.

As indicated by Table 1, patients often described plural aetiologies for one given condition, both at the Delek Hospital and in the Men-Tsee-Khang. Interestingly, disease agents such as the *'bu* or *srin bu* occupied an aetiological space between traditional and biomedical medicines. A more detailed look at the contemporary use of concepts like *'bu* enables us to clarify the complex negotiations of aetiology operated by exiles.

The concepts of *'bu* and *srin bu* both feature prominently in contemporary Tibetan exile understandings of disease. However, when exiled Tibetan medical doctors attempted to translate the term *srin bu*, some were satisfied with the generalising and biomedical label 'micro-organism', while others adopted the more differentiated terms 'parasite' and 'bacteria'.[8] In classical Tibetan medicine, the body is said to possess an internal *srin* which is occasionally disturbed by the invasion of external *srin*, perturbing the functioning and equilibrium of the three humours.[9] Traditionally, the term *srin bu* can designate an insect and a worm, but also a savage, a barbarian, a ghost or a spirit.[10] An exploration of the etymology of the term *srin* indicates a close relationship between these spirit-demons, and the environment: the *srin po* is a cannibal demon, and one of the guardians of the ten directions (*phyogs skyong bcu*).

The *srin bu* are thus traditionally associated with specific places. Other such place-specific spirits are commonly mentioned in Tibetan explanations for disease: the *klu*, for example, are water spirits residing in springs that are said to cause diseases of the skin, boils and leprosy when offended. The implication of place-specific contagion in common diseases is unsurprising when one considers that places and landscape are a powerful source of imagery and identity in Tibetan cultural areas (Buffetrille and Diemberger 2002). One might argue that, in traditional Tibetan medicine, parasites, demons and places are linked because diseases are understood to a large extent as diseases of place, offering an example of what the sinologist and historian of medicine Paul Unschuld termed localistic aetiologies (Unschuld 1985).

Yet while the connection between disease and place remains potent, the old affiliation of *srin* to demons, misdeeds, and moral contamination is obviated in contemporary Tibetan medical practice. Contemporary Tibetan medical practitioners in India refer to the *srin bu* as micro-organisms or parasites, and certainly not as demons. In the medical curriculum of the Dharamsala Men-Tsee-Khang, texts about

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[8] Herbal compounds prescribed by exile Men-Tsee-Khang practitioners for *srin nad* (*srin* disorders) include *Dha due*, *Gawa* 16, *Pang tsi* 12, *Chi srin* and *Khung nga*.

[9] Cf. Dorjee and Richards 1985: 36–37.

[10] According to Das, the *srin po* are "cannibal demons, figuring in Indian and Tibetan mythology, with red neck and eyes, which drink blood and subsist on dead bodies (...)" (2000 [1902]: 1290). See also the depictions of *klu'i srin po* (Nāgarakṣha) from the Rnying ma lineage, and the subjugation of the *srin mo* during the construction of the Jokhang temple evocatively depicted by Janet Gyatso 1989.

srin have been regrouped under the general category of 'parasitology',[11] while texts about demons and especially traditional Tibetan nosologies have been more or less expurgated.[12] This purging of the more esoterical elements of Tibetan medicine in the curricula of both TAR and exile medical schools[13] has been commented on elsewhere (Samuel 2001; Adams 2001; Jacobson 2000) and I do not wish to elaborate on this here. The different interpretations given to the notions of srin, however, testify to the diversity of political influences over contemporary Tibetan medicine, influences that shape its practice along different lines in the Indian exile, in the TAR, and globally.

In exile and in the Tibet Autonomous Region, the *srin* have been given renewed importance because of their homology with the biomedical concepts of bacteria and parasites. Vincanne Adams and Craig Janes[14] have convincingly argued that traditional doctors in the TAR are under increasing pressure to make their practice seem more 'scientific', more secular, and more compatible with biomedical intervention on the body. In Europe, Tibetan doctors working for recognition in the new European Herbalist Practitioners Association, write that the diseases of *srin* are "infections and inflammations caused when micro-organisms always present in the body become pathogenic".[15] In India, the term *srin* now regularly finds its way into discussion of infectious diseases as a term designating biological disease agents, as does the word *srin bu*, i.e. 'parasite', which is now often used to designate the concept of bacillus when talking about tuberculosis.

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[11] This is how the sections on *srin bu* are referred to in the English translations of the curriculum outline.

[12] This was already noted by Samuel 2001. The Dharamsala Men-Tsee-Khang has gradually minimised the study of more 'esoteric' sections of the *Rgyud bzhi*, as well as the sections dealing with traditional anatomy and primordial causes of disease. The majority of the sections that have been taken out of the study of the *Rgyud bzhi*'s *Bshad rgyud* deal with traditional Tibetan anatomy, physiology and medical instruments (including 'surgical' instruments). Similarly, the Men-Tsee-Khang teachers have discarded the majority of chapters dealing with classification of the body and disorders. Thus, the *Man ngag rgyud* is the least memorised of the Four Tantras. Only a third of its 92 chapters are memorised by students although they do need to be studied.

[13] Albeit far more forceful in the TAR.

[14] Cf. Adams 2001, 2002 and Janes 1995, 1999 and 2001.

[15] See the European Association of Herbal Practitioners' document on traditional Tibetan medicine available online at http://www.users.globalnet.co.uk/~ehpa/Tibetan8thJul03.pdf, p.10.

It has been argued that Tibetan medicine in exile is taking a different trajectory from medical practices in the TAR.[16] While Tibetan medicine in the TAR is being transformed into a quasi secular, aspiringly scientific and lucrative enterprise, Tibetan doctors in exile are more cautious in secularising their curriculum and practice. This may be explained by the fact that the Tibetan Government in Exile has invested the Men-Tsee-Khang with the mission of preserving traditional medicine as one of the great Tibetan traditions, one that is inextricably tied to Buddhism. While in theory at least, this should mean preserving the more esoteric components of the tradition, in reality, the message given to patients and doctors about this is often contradictory. Although the efficacy of Tibetan medical practice is said to stem from the system's holistic understanding of the interdependence of external and internal biomoral elements like the three humours and karma, the Dalai Lama and a host of medical practitioners insist that Tibetan medicine is efficacious regardless of whether the patient is Buddhist or not. Thus Men-Tsee-Khang practitioners are now faced with the challenge of secularising elements of the system while retaining the Buddhist principles fundamental to Tibetan conception of disease and health.

This may explain why elements such as the *srin* have been decoupled from their demonological affiliations and are instead associated with biomedical concepts, while remaining compatible with discussions of humoral imbalance and karma. But if the demons have, at least symbolically, been expelled from medical diagnostics in the TAR, as Adams and Janes suggest, and the *srin* are now only bland laboratory-type parasites, how do they fare in exile, a place where diseases abound, and particularly diseases of place and displacement? Tibetan herbal medicines are now being sold far beyond the borders of the TAR and India, but have the demons and parasites of place crossed borders?[17] In order to offer some answers to these questions, I now want to further explore the interconnections between place and notions of contagion in Dharamsala.

[16] See Samuel 2001.

[17] I am reminded here of Murray Last's insight that herbs may be transnational, but spirits remain local (Last 1990). I am also grateful for Mona Schrempf's comment on exile Tibetans' narratives of encounters with local spirits such as *klu* in India.

Diseases of Place

Exile has modified conceptions of health among Tibetans, and through this, the practice of Tibetan medicine, along with its theoretical underpinnings. Politically informed notions of contagion and pollution in particular are significant elements in exile conceptions of health and illness. Discrete social groups like newcomer refugees from the TAR and young women especially,[18] by virtue of being associated with the danger of acculturation and social change have become the focus of fears about social contamination. This is critical because it informs popular beliefs about epidemiological contagion and public health agendas, in the sense that newcomers and young women are construed as both more vulnerable to diseases, and also more likely to transmit them.

In exile, the contamination of place is a subject of great concern and a prominent aspect of popular discourse on illness. This is visible in the growing preoccupation with pollution in the exile environment, for instance attacks from dangerous 'micro-organisms' (again referred to as *'bu*) in food and water and of the 'air pollution' (*rlung btsog pa*) caused by the increasing amount of motorised traffic in Dharamsala (see Table 1). This underscores the prevalence of the belief that the exile environment itself is a health hazard to Tibetans, and that Tibetan refugees fall easily ill in India because of the exposure to unknown bacteria, parasites, pollutants and foods.

The radical changes experienced by Tibetans with the move to India in the 1960s and thereafter have had a very real impact on health and morale in the community. One researcher explains that:

> a feeling of despair grips Tibetan youth who have difficulty finding employment within their own communities (...) [they] either move to large urban cities which may only have a small Tibetan community or none at all; or they attempt to emigrate, which is almost impossible; or they stay in their own communities and are under-utilised.[19]

One Tibetan student explained her view of the relationship between exile and illness:

> *Sa cha 'di ma 'phrod na, sma dang na tsha 'dra min 'dra yong gi red*
> If this place doesn't agree with you, wounds and diseases will come.

[18] For a more detailed discussion of the stigmatisation of young and upwardly mobile women in the exile community see Prost 2004.

[19] Seidman 2004, http://www.comminit.com/materials/materials/materials-457.html.

Refugeehood and exile are clearly identified as sources of ill health and suffering. When I questioned Tibetans on the subject of prevalent illnesses in their homeland, many told me that Tibet is free of the diseases endemic to the subcontinent because of its high altitude and dry, cold climate. This belief is encapsulated in the following words from a retired Tibet-born soldier, which are constantly echoed among exiles:

> *Bod la rlung rbad de gtsang ma dang sa 'dzam gling nas mtho shos yin tsang na tsa 'dra min 'dra yod ma red*
> In Tibet the wind is always blowing and it is the highest place in the world, therefore there really is no disease.

Most of the Tibetans I interviewed in the biomedical Delek Hospital and the Dharamsala Men-Tsee-Khang had experienced new 'Indian' disorders such as malaria or dysentery upon their arrival from Tibet. There was a clear sense to which people believed that most refugees got sick when arriving in exile. Many exiles also reported long-term chronic conditions which they believed were the result of the change in environment experienced with the move to India.

In addition to the focus on disease agents pertaining to the environment and the place of exile, Dharamsala settlers often commented upon the social context of public health problems like the prevalence of diseases such as TB and malaria. Such health disorders were depicted as 'diseases of exile', that is, as diseases caused or exacerbated by the social context of exile. This explanation was not offered in explicitly politicised terms,[20] but rather with reference to locally salient Tibetan social issues. Some of the lay groups I interacted with, including housewives and newcomers, thought that the main causes of health problems in the community were poverty and social isolation. The lack of opportunity, idleness, and despair associated with loneliness and the new surroundings of exile were seen as conducive to disease. In my experience though, while the youth have become accustomed to talking about *sems khral* (worry) and *sdug bsngal* (suffering, misery), the more elderly generation tend to emphasise *las* (karma) and factors like the weather or diet, which they see as the principal determining factors for health. India's hot climate, the way foods seem to rot and the *'bu* proliferate,[21]

[20] I have never heard anybody say "India is the land of *rlung*" for instance.

[21] Epidemiological surveys conducted with the Department of Health indeed indicate a high incidence of gastro-intestinal and diarrhoeal diseases in the 30 settlements and 47 scattered communities. See also Punkhill 1992.

the lack of winds, the lack of space, are all seen to contribute to the rise of *mkhris pa* and *rlung* diseases as well as stomach upsets.

Most public health problems are reflected upon within the context of exile social change. It is therefore not surprising that the prevalence of tuberculosis among exiles, which has been characterised as a humanitarian emergency by the head of the TB programme in Dharamsala, has seen a proliferation of metaphors and images in its wake. TB primarily strikes adolescents and the elderly, the two generations in which exile social change is most strongly embodied, and who are the most socially vulnerable members of Tibetan exile society. Afflictions displayed by these two groups therefore take on strong moral undertones and these patient groups become subject to a particular kind of social scrutiny.

I now turn to examining how ideas about the dangers inherent to social change impact on perceptions of disease and contagion. A common theme underpinning these case studies is the notion of risk-group, the idea that certain segments of the exile population are categorised as 'at risk', i.e. more vulnerable and contagious, both socially and epidemiologically. The two groups with which I am concerned here are firstly young women, and secondly refugees recently arrived from Tibet, the *gsar 'byor ba* or 'newcomers'.

Many illnesses were linked to a perceived degradation in young people's morale. Most commonly, the youths' alleged idleness caused by the lack of employment opportunities in exile, was thought to encourage risk-taking behaviour. In popular discourse, TB was thought to thrive among young girls preoccupied with dieting and looking good. The girls were said to be too concerned with their physical attractiveness, which led them to skip meals and become emaciated. Thus, in the marketplace, older women pointed out girls who displayed characteristic 'stains' (called *sha rtags*)[22] on their faces, which are said to be cause by malnutrition.[23]

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[22] This term was translated by my informant as 'mark on the flesh', although Goldstein (1984) translates it as 'birthmark'.

[23] The perceived morally reprehensible character of young women's concern with attractiveness might explain the crisis caused by the 2003 Miss Tibet beauty pageant organised in Dharamsala. Only one contestant turned up for the pageant amidst a storm of protest from the more traditional segments of the exile community. The pageant's organisers revealed that the girls had been under intense social pressure not to participate.

Concern with the changing mores of young female adolescents was reflected in the stigmatisation of girl's TB as a disease of exile modernity, embodying a growing preoccupation with bodily appearance and defiance of the older generation's more conservative views. This was linked to the emancipation of young women in exile and their increased access to education and employment, which was perceived as a radical departure from the older female refugees' more simple lifestyles. The perception of infectious diseases such as tuberculosis can be understood as involving a medicalisation of social change in popular Tibetan exile culture, as for example in the stigmatisation of skinny, modern, fashion-conscious girls.

I would contend that Tibetan exile discourses about TB focus on adolescents in part because the vulnerability of this group has come to embody the vulnerable state of exile society at a time of profound social change. The older generation of refugees is disappearing and giving way to a new generation born in exile. The exile community is therefore apprehensively chronicling the growing cultural chasm between young exiles born in India, newcomers, and older settlers. Fears about the contagiousness of social change are expressed by identifying risk-groups in Tibetan society—at risk both socially and epidemiologically.

The second risk-group is that of newcomers, i.e. new refugees recently arrived from Tibet. The Tibetan Government in Exile's difficulty in coping with the growing numbers of newcomers matches that of the local community in accepting them.[24] The tension between earlier refugees and the newcomers is potent in Dharamsala. Newcomers are the object of all suspicions and the recipients of accusations for multiple social ills. Diseases like tuberculosis in particular, are associated with the so-called 'irresponsible' and 'asocial' attitude of uncouth and 'contaminated' newcomer youths suspected of not observing the public health measures recommended to avoid spreading the disease.

A cluster of issues crystallising questions of identity and belonging is at the heart of the newcomer/older settler tension. Earlier refugees tend to see newcomers as immigrants, and thus competition for jobs

[24] The majority of these newcomers now originate from the eastern provinces of Kham and Amdo, parts of which are the poorest regions of the TAR, and those that have come most heavily under Chinese influence. Many of them, having received very little Tibetan education, speak only Chinese and a Tibetan regional dialect. They thus come to India unprepared for a confrontation with their more learned and established compatriots.

and sponsorship opportunities. The stereotypical depiction of the newcomer among older Dharamsala settlers is of an uneducated, rough and ready opportunistic entrepreneur.[25] Newcomers bring with them an image of home that does not always fit with the high expectation of 'true' Tibetan behaviour acclaimed by Tibetan exiles. To many, they appear unsophisticated, incongruous in Dharamsala's cosmopolitan environment. While health issues are interpreted with reference to Dharamsala's changing social organisation, social change itself has to some extent become pathologised. This is manifest in the popular concern with newcomers bringing diseases into the community, or encouraging the spread of diseases through their weakened resistance to them. Thus, older refugees commented on some newcomers' reckless attitude toward TB prevention measures, reprimanding them for walking around town without cotton masks on their faces, as if they did not care about infecting others. To a certain extent, newcomers are construed as socially and epidemiologically dangerous. They foster social unease because they tend to form groups bound by regional or circumstantial solidarity that transgress the implicit rules of communal solidarity fostered by exile politics.[26] Despite this, the newcomers' diseases are sometimes seen as part of the necessary process to become an 'exile'.

The newcomers' typical exile trajectory, from refugee reception centres to transit schools, might thus be seen as part of a process of social quarantine, a course of action necessary to contain the social and physical contagion which they represent, so that they can finally be accepted into the encultured body of exiles. By the same token, newcomers often describe critical illnesses experienced during their first few

[25] As exemplified by one joke from a 'Gangkyi' civil servant born in India:

One day a newcomer arrives in Dharamsala and visits the Library [of Tibetan Works and Archives]. Seeing the great work done by people there and how many injiys [foreigners] it is attracting, he decides that he too can make some profit and opens up a tourist bureau. From there he takes tourists to Bodh Gaya and the Bodhi tree [the site of the Buddha's enlightenment], where he says: 'Here the Buddha spent many years, pillar cutting... (*ka ba bcad*).'

The newcomer interprets *ka ba bcad* literally rather than in its religious context, meaning eliminating suffering.

[26] Another complicating factor in the tense relations between refugees and newcomers is the persistent rumour that some of them are sent from Tibet to 'spy' on activities in Dharamsala, in particular on those of the Government in Exile. The fear of 'spy invasions' regularly rocks the community as reported in Dharamsala's local press (eg. *bod kyi dus bab*). Conspiracy theories about newcomers have increased public vigilance and suspicion.

months in exile as rites of passage which shape their transition to the exile world. Among the newcomers from Tibet, low morale caused by social isolation and disillusionment is also perceived as a source of ill health. This is most apparent among the transit school students visited on a bi-weekly basis by Men-Tsee-Khang doctors, the majority of whom are diagnosed with strong *rlung* disorders. The doctors explained to me that the newcomers' minds are constantly occupied with sad and anxious thoughts and that this was the source of their *rlung* problems. One female Men-Tsee-Khang doctor recalled "this is the first thing you notice in Sogar school[27] patients, they have so much *rlung*, you can feel it as soon as you take their pulse".

Thus the social boundaries which exiles set up amongst themselves are invoked in relation to disease, to identify outsider groups as more at risk, more contagious, less socially responsible. Such implicit moral allegations are intimately linked with the idea that earlier exiles are repositories of true, authentic Tibetan culture, and that outsiders, newcomers, and dissolute youths are 'contaminating agents' both socially and physically, and threaten the survival and purity of the group.

The Men-Tsee-Khang: Providing Medicine for Displacement

In the final part of this paper, I want to look at the ways in which the uncertainty of exile and the identification of risk groups have affected the practice and theory of Tibetan medicine. As a form of socially sanctioned traditional knowledge, traditional Tibetan medicine is employed to counteract feelings of anxiety caused by the exile environment, and the disruption caused by environmental, behavioural and dietary changes among exiles. One of the ways in which this manifest is in the booming demand for prophylactic traditional medicine like the precious pills (*ma ni ril bu*) blessed by lamas and distributed in commemorative ceremonies. The pills are part of the broader category of empowered sacred substances called *byin rden*, like seeds or waters blessed by high lamas on ritual occasions.

Byin rden substances like these pills are kept within homes for months and distributed to friends and family. They are consumed by family members whenever illness occurs, first preventatively, then

[27] Also known as the Tibetan Transit School.

sometimes as a complement to other medicine, often biomedicine. For example, when three members of a family I knew had fallen ill after the Tibetan new year's feasts, suffering from fevers and stomach pains, the female household head promptly proceeded to produce a cocktail of aspirin and Tibetan pills which were taken together, "crushed one straight after another" (*zhib zhib bzos dgos red*) in the same glass of 'boiled water' (*chu khol*). The *byin rden* can also be taken when a special blessing is required. For instance, students take the pills before government examinations to help them cope with tiredness.[28] Empowered substances are therefore used as prophylactic medicines that help Tibetans protect themselves against the vicissitudes of a hostile exile environment.

In addition to the arsenal of *byin rden*, exiles also attribute prophylactic and curative properties to substances that come from Tibet, substances that have acquired a strong affective meaning in the Diaspora. For example the traditional belief in the medicinal properties of butter and milk is often discussed in the context of exile: "In Tibet, water tastes like milk", I was once told by an elderly nun, or another variation: "the milk in India tastes like the water from Tibet". Foods and drinks from Tibet are seen as especially nutritious and vitality-enhancing: yak meat is said to be richer and its taste more pungent than any meat available in India. One may suggest that there is a homology between the use of food brought from Tibet and that of *byin rden*: both are considered to have curative, protective and vitality-enhancing qualities. Offering food from Tibet may be considered a virtuous act much in the same way as a gift of *byin rden* is. Exile therapeutic and prophylactic materials thus include a wide variety of substances, which have the common property of being allegedly infused with the bio-moral qualities of places, like dried yak meat, or persons, like these blessed pills.

But the harmful effects of the exile environment are of course not only restricted to food: dissatisfaction with the place of exile run far deeper. Conversations often turn to bodies and their discomforts (*lus ma longs*) and refugees often describe the suffering of exile as an embodied maladjustment to their surroundings. Tibet's mountainous,

[28] Samuel, citing Rozario 1996, has argued that "people may take *byin rden* if they feel in a vulnerable situation for example, when selling sweaters on the streets of dirty and polluted Indian cities or when going to an Indian hospital for the delivery of a child" (Samuel 2001: 250).

wind-swept expanses are contrasted to the crowded Indian settlements where dust and pollution make Tibetans sick. The change of environment occasioned by exile itself is seen as a source of ill health: foods rot too quickly; it is too hot; one cannot always wash one's body or wear clean clothes; one's stomach gets upset; animals and insects eat one's clothes and papers, humidity spoils food and clothes, disease and germs abound. Thus place and place-related substances play key role both as causative factors of disease, and as therapeutic aids.

Popular exile conceptions of health make great use of notions of contagion, contamination and pollution. The revival of notions like *'bu* and *srin bu* in exile operates a slippage whereby entrenched beliefs about the contagiousness of place come to take on new forms linked to the current social predicaments of exile. Exile is a pathogenic place where social contamination rapidly becomes an epidemiological threat. In exile, parasites and invasive micro-organisms are allegories for moral faults, but also pseudo-biomedical entities implicated in the spread of infectious diseases like TB Tibetans have been quick to adopt the biomedical depictions of bacteria and parasites because biomedical epidemiology resonates with earlier understandings of *srin* and the contagiousness of place in traditional Tibetan medicine. Moreover, Tibetan medicine works in exile precisely because it stipulates that diseases are diseases of place, of diet, climate and lifestyles. Tibetan medicine's emphasis on locatedness as aetiology is its strength in a place where people suffer from dis-location.

But what role has traditional Tibetan medicine played in addressing the public health issues arisen out of displacement? Since its inception in 1961, the exile Tibetan Men-Tsee-Khang has become a powerfully defining force in Tibetan medical theory and practice outside the TAR. The Tibetan doctors' constant engagement with diseases of exile has naturally influenced their practice of medicine. But, perhaps more importantly, the inherent hardships of exile have invested traditional medicine with a special role. Traditional Tibetan exile medical practice is a ground where the religious underpinnings of health collude with the political agendas of exile such as Tibetan nationalism and the politics of Tibetan survival in exile. One might argue that traditional Tibetan medicine's contribution to Tibetan exile public health is twofold. Firstly, through the diffusion of medicines such as precious pills and *byin rden*, traditional medical institutions like the Men-Tsee-Khang in Dharamsala perpetuate and reinforce the connection between

health and religious practices. This bridge is critical in that it re-establishes the importance of virtuous conduct and good relationships with others as producing wellbeing and health.

Secondly, adherence to Tibetan Buddhist principles is congruent with the political agenda of exile politics, i.e. the preservation of 'Tibetan culture and tradition'. By endorsing traditional medicine as a key element of Tibetan exile culture and encouraging its preservation, the Government in Exile has contributed to making it an important institution in the provision of healthcare. One might also venture that, as a government sponsored practice, traditional Tibetan medicine in exile is held up as a cultural force that reinvigorates nationalistic sentiment and, to a certain extent, counterbalances the creolising influences of newcomers and foreigners in Dharamsala. Newcomer contagion, I suggest, can be contained and transformed through the power of practices that reaffirm exile-Tibetanness, such as attending religious teachings or taking Tibetan medicine.[29]

Thirdly, dealing with prevalent exile disorders such as *rlung* diseases has become a matter of public health, linked to the biomoral imperative of survival in exile.[30] The Men-Tsee-Khang's role in defining an alternative public health agenda is clear from its commitment to offer services in all Tibetan exile settlements in parallel to allopathic clinics.[31] The Men-Tsee-Khang students' strong ethical cum religious positions on public health issues, their writings about the importance of not drinking, smoking, following the guidance of religious teachers, explicitly link the survival of Tibetans in exile to a prescriptive biomoral pro-

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[29] I am grateful to Mona Schrempf for helping me articulate these ideas.

[30] The Dalai Lama's commitment to non-violence and its correlated biomoral ethics draws much from Gandhi's idea of satyagraha. Discussing the link between ahimsa, satyagraha and Gandhi's agenda for public health, Alter writes: "non-violence was, for him, as much of an issue of politics, morality and religion. To read ahimsa simply as practical philosophy, political theory, ethical doctrine, or spiritual quest is to misunderstand the extent to which Gandhi embodied moral reform and advocated that reforms embodiment in terms of public health- a kind of health which may be understood as inherently political, spiritual, and moral in the context of late imperialism" (1996: 304). Although the Dalai Lama's commitment to the prescription of dietary and behavioural programmes is certainly not as stringent as Gandhi's was, he plays an important role in publicising the strengths of Tibetan medicine for healthy living.

[31] The CTA's Department of Health reports that there are 61 Primary Health Care centres and eight referral hospitals under its aegis, and that the Men-Tsee-Khang at present has 37 branch clinics in India and Nepal. Both biomedical and traditional facilities are under the supervision of the Tibetan Department of Health.

gramme.[32] Their involvement in public health and dealing with problems like *rlung* outbreaks can also be understood as part of the Institute's adherence to a greater agenda of political and moral reforms that invests Tibetans with the responsibility of non-violent activism. The promotion of Tibetan medicine by the Dalai Lama as a culturally adequate system of healthcare with foundations in Buddhist practice elevates Tibetan traditional medicine to the role of key provider of healthcare and orchestrator of public health.

This is arguably a delicate role, as it involves negotiating a working balance between the religious affiliations of medical practice and the growing need for scientific credibility. Being conversant in the idiom of biomedical science is of increasing importance to Tibetan traditional practitioners in exile: the legal status and commercialisation of Tibetan medicine abroad hinge upon the successful completion of trials using biomedical standards.[33] In addition, the Tibetan Government in Exile's endorsement of the complementarity of Tibetan and biomedical systems means that healthcare and health promotion in the exile settlements demand efforts at co-operation on the part of both biomedical and traditional medical services.

Conclusion

Many prevalent health conditions in Dharamsala are presented as diseases of place because they are perceived to arise from a) changes in environmental and dietary factors; b) socio-cultural and psychological factors such as the demoralisation of young people and the uncertainties of exile. I propose that this results in the creation of risk-groups such as young women and *gsar 'byor ba*, who are seen as both more vulnerable and more likely to transmit disease. The notion that, in times of health crises in particular, there tends to be a coalescence between metaphors of social contagion and epidemiological contagion is of course by no means a novelty.[34] However the confluence of social and

[32] The writings of Men-Tsee-Khang students in Gang ri la tso clearly link health promotion to religious practice. See Tenzin Namdul's 'Dying Young Expensively' (1996: 9–11) on the use of cigarettes and alcohol by young exiles; Pema Sangmo's 'Preservation of Our Culture' (1997: 35–36).

[33] Cf. Men-Tsee-Khang 1998; Namdul *et al.* 2001.

[34] See for instance Douglas 1966; Malkki 1995; Wallman 1996.

medical contagion theories is reinforced when local medical systems place particular emphasis on localistic aetiologies, namely when doctors and patients stress that place and place-related contagion are important causes of illness. This is the case in Tibetan medicine, which emphasises environmental, dietary and seasonal changes as primary factors in disease. This emphasis is strengthened in the context of exile, where Tibetans are confronted to drastic changes in their environment. The popular concern with *srin bu* and *'bu* reflects a real epidemiological threat to the community and also contributes to re-shaping traditional Tibetan medical notions to accommodate these changes. I argue that Tibetan medicine is particularly efficacious in exile because it deals with problems of place, because it is, in its very theoretical core, localistic, and is therefore particularly well suited to a community that has a problem with displacement.

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SHERPA BELIEFS AND WESTERN MEDICINE: PROVIDING HEALTH CARE AT KHUNDE HOSPITAL, NEPAL

SUSAN HEYDON

One evening, a woman was returning with some of her family members from a neighbouring village to her home in Khunde when she fell off the narrow track and was severely injured.[1] Many villagers helped rescue her and she was carried to the hospital. It was the view of the family that the woman's personal god, her *lha*, was upset and had caused *hrindi*, the 'ghosts', to push her off the trail.[2] To the doctor and staff at the Khunde Hospital the woman had stumbled and then fallen several metres down the steep mountainside. She was unconscious and had multiple unknown external and internal injuries. The family lived not far away and had used the hospital on other occasions. They said the doctor could try and treat her, but on the condition that if he thought she was going to die the family must be allowed to take her away so that she could die at home. Hospital staff had told the doctor before of the importance within Sherpa culture of dying at home.[3] For three weeks the woman remained unconscious at the hospital, but she was alive and various fractures and problems were treated. During this time the people of the villages of Khunde and Khumjung, who shared the gompa (temple) at Khumjung, were preparing for Dumje, the main festival for the wellbeing of the whole community, and which was held over several days. During this festival, Khumbila, the most sacred god of Khumbu, came down from his mountain home above the hospital and village, and danced at the gompa. The woman's husband asked if the

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[1] The story comes from participant observation while working as a volunteer at Khunde Hospital from 1996 to 1998.

[2] Sherpa language is one of many dialects of spoken Tibetan. However, written Tibetan, which is used in religious texts, is unfamiliar to almost all lay Sherpa. There is no standard system used for phonetically rendering Sherpa words, and this has sometimes led to variations of orthography. Khunde, for example, is often spelt as Kunde.

[3] By speaking of 'Sherpa', in this chapter, I mean the Sherpa of Khumbu. Sherpa are not one homogeneous entity, since there is considerable regional and internal variation amongst groups of Sherpa, such as those of Khumbu, Solu or Rolwaling, or further afield in Kathmandu or Darjeeling in India.

doctor would mind him going to pray to Khumbila. The doctor thought it was a good idea and the husband offered his prayers. The doctor and staff also went each day to attend the ceremonies during the festival. The following morning the woman's level of unconsciousness began to improve and two weeks later she walked home from the hospital.

In 1966, New Zealander Sir Edmund Hillary, together with a group of overseas helpers and local villagers, built the small hospital at Khunde as part of a wider aid programme to assist the approximately 3000 mainly Sherpa people in the Khumbu area of Nepal near Mount Everest.[4] Considerable change has occurred throughout the region since the arrival of the first Western visitors in Khumbu in 1950, and the subsequent development of the area as one of Nepal's principal tourist destinations.[5] The aim of this article is to explore how continuing Sherpa beliefs and practices about ill health in Khumbu influence the provision of Western health care services. This will be done by looking historically at people's encounter with services provided from Khunde Hospital.[6] Sherpa beliefs and practices have remained strong amidst a range of forces promoting modernisation, and are the key to understanding not only what Sherpa people did when they were sick but also to understanding how the hospital has responded to sickness among the Sherpa. Perhaps the above story would have been less surprising in 1966 when the hospital first opened, but this encounter occurred more than 30 years later, and neither hospital nor patient and family thought it unusual.

The 1960s, when Khunde Hospital was planned and built, was a time when Western medicine was extremely optimistic about what it could achieve. The rural health care model of a small hospital with a Western doctor could be found in many places around the world. Nevertheless, when reviewing Khunde Hospital's first nine months of operation John McKinnon, the hospital's first doctor, wrote of mixed responses to the 'modern medicine' which the hospital offered for free, but thought that

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[4] Khumbu is the Sherpa name for this area. It is part of the Solukhumbu district of the Eastern Development Region of Nepal.

[5] The area is now part of the Sagarmatha National Park.

[6] Khunde Hospital practises what is variously—and often controversially—referred to in the literature as Western medicine, modern medicine, scientific medicine, biomedicine or allopathic medicine. In this article 'Western' will be used most often because it best describes the practice of medicine at Khunde, both in terms of medical services and of the establishment of the hospital through Western aid organisations. Sherpa view it as 'modern medicine'.

> The passage of several years, with exposure to modern medical practice and local publication of therapeutic successes will lead to even greater acceptance.[7]

McKinnon believed that three interventions, in particular, gave good initial publicity to the hospital: the decrease in the size of the goitres (caused by iodine deficiency) brought about by iodised oil injections; the treatment of tuberculosis, which was then widespread and caused a high mortality; and the extraction of rotten teeth, which offerred freedom from what were often years of pain.[8] Five years after the opening of the Hospital, Dr. Lindsay Strang wrote in his annual report that

> Western medicine continues to be accepted only slowly and still traditional forms are often resorted to initially especially for serious conditions.[9]

The overseas staff of the hospital were becoming used to offering Western medicine in a setting where the often anticipated inherent supremacy of Western medicine in non-Western contexts did not appear to apply. Treatment might be refused and advice often ignored. It was not uncommon to find more than one type of traditional practitioner at a person's house. Such early reports from the hospital's staff clearly reveal the complexity of the encounter between Sherpa beliefs and practices and those of Western medicine. The volunteers at Khunde Hospital were uncertain as to the outcome of this encounter, and proving the efficacy of Western medical treatment was extremely important for them.

SHERPA BELIEFS AND PRACTICES

The Sherpa of Khumbu are an ethnically Tibetan people who first migrated over the mountain passes of the Himalaya in the early 16th

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[7] McKinnon 1968: 142.

[8] Interview with Dr. John McKinnon, Khunde, March 1997. A goitre is a swelling of the thyroid gland at the front of the neck, and they were extremely common in Khumbu during the 1960s.

[9] Khunde Hospital Annual Report for the Year Ending 31st October 1972.

century, into what was then an uninhabited area.[10] In the 18th century, the area became incorporated into the Gorkha kingdom that now forms the modern state of Nepal. The new rulers were Hindu while the Sherpa, like a number of small groups living along the Himalaya, were Buddhist. Both their geographically remote location in the high valleys of the rugged mountains near Nepal's border with Tibet, and their low social and political position in Nepal, meant that, apart from the payment of taxes, the Sherpa were of little interest to the Nepalese state and were left to themselves. Sherpa lived in villages and largely managed their own affairs, with their livelihood based on a mixture of agriculture and pastoralism. This was supplemented by trade, as the area was located on a long-distance trade route between northern India and Tibet. An alternative to this way of life was to leave Khumbu, on either a temporary or permanent basis. One popular destination in the 19th century was Darjeeling in British India, where the first district census in 1901 recorded 3450 Sherpa.[11] While Sherpa found employment in a variety of occupations, during the first half of the 20th century Darjeeling became an important recruitment centre for Sherpa accompanying climbing expeditions in the Himalaya. During this period, the Sherpa became renowned for their key role as high-altitude support personnel for these expeditions, a reputation that was built both on their ability and personal attributes.[12] The name Sherpa became synonymous with their occupation on mountaineering expeditions.[13] One of these was Tenzing Norgay, who was born in Tibet, but came to live in Khumbu as a child, and later moved to Darjeeling. In 1953, he and Edmund Hillary were the first people to stand on the summit of Mount Everest. The event thrust both men—and the Sherpa generally—onto the world stage.

While many people in Khumbu would have heard of the type of medicine offered by Khunde Hospital, and while some—particularly those people employed by the expeditions—may have used it, Sherpa

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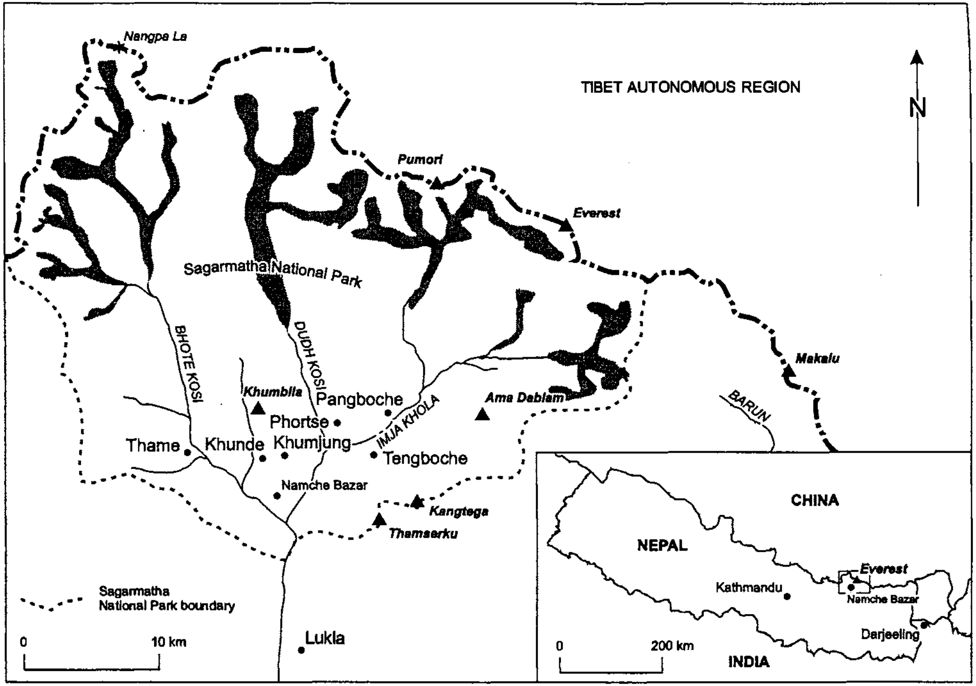
[10] There are many academic and popular studies of the Sherpa, ranging from the 1950s until today. Christoph von Fürer-Haimendorf's *The Sherpas of Nepal: Buddhist Highlanders*, published in 1964, was the first academic study and remains the broadest account. Fürer-Haimendorf's subsequent publications in 1975 and 1984 considered aspects of change.

[11] Dash 1947: 72. This total would have included Sherpa from other areas.

[12] The role of the Sherpa in expeditions is described in many accounts, but see Ortner 2000, and Adams 1996.

[13] This has led to confusion. In this article, Sherpa only refers to the ethnic group.



Map : Solukhumbu District and Sagarmatha National Park, Nepal

beliefs and practices about sickness at the time the hospital opened revolved around a different cultural system from that of the overseas volunteers who came from New Zealand to work at the hospital.[14] Sherpa inhabited a world that was full of various types of beings who could be dangerous if offended or ignored, but who could also be appeased through appropriate measures.[15] Sherpa responded to the origin of problems in one's affairs or to sickness of humans, animals or crops in much the same way. Dealing with such forces was—and continues to be—an integral part of Sherpa life. This means that Sherpa people do not see health or sickness in isolation from other things that are happening. Various agents can be at work to cause problems, but the ones that people most worry about are those that can suddenly cause something nasty to happen—such as death.[16] Sometimes one of these agents acts alone, but often it is believed that there are more than one that cause problems.

Traditionally, Sherpa could employ a number of strategies to deal with sickness and still do so today.[17] Finding out the cause of sickness takes precedence over dealing with the symptoms, although the perceived severity can influence whether or not the patient or family seeks assistance.[18] People can try and prevent sickness. A person needs to increase their store of 'good luck' (*lungtar*) so that he or she is in a better position to combat the various forces working against them. Sherpa practise the Rnying ma pa form of Tibetan Buddhism and religious ceremonies are held throughout the year. Some ceremonies, such as Dumje—referred to in the story at the beginning of this article—are

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[14] Khunde Hospital is run by the Himalayan Trust, which is chaired by Sir Edmund Hillary in New Zealand. Volunteer appointments have been made from New Zealand, or more recently from Canada, which has provided considerable funds for Khunde Hospital since the late 1970s through the Sir Edmund Hillary Foundation and the Canadian International Development Agency.

[15] Sherpa beliefs about *nerpa*, *lu*, *lha*, *pem* or a form of pollution referred to as *thip*, as well as what people did when they were sick, have been extensively described elsewhere. See Adams 1989 and Draper 1995. For a useful short article from the point of view of Khunde Hospital doctors, see Dawson and Uhrig 1984.

[16] Emphasis given by Kami Temba Sherpa, now Dr. Kami Temba Sherpa and Medical Superintendent, Khunde Hospital, in an interview with the author in Suva (Fiji), September 1999.

[17] This use of generalisations should not mask the variation that has existed, both over time and between and within villages.

[18] Interviews with Kami Temba in Suva, 1999, and Ang Rita Sherpa, Chief Administrative Officer of the Himalayan Trust and Chairman of the Himalayan Trust Advisory Committee, Kathmandu, June 2003.

performed for the benefit of the whole community, while others are intended for an individual person or family. Merit can also be earned through various individual activities. Particular years, months or days are more risky than others to embark on a major project. For some illnesses, such as *chhamba* (the common cold/mild headache/cough), no further action is considered necessary. Sherpa can also consult a healer to try and identify the cause of their problem. The two main choices of local healer are the lama and the *lhawa* (spirit medium).[19] People make a preliminary decision about which type of practitioner to call, but when a person is very sick they often resort to both. Customary family practice also influences selection.[20]

Sherpa also had another option in dealing with sickness–consulting an amchi, a practitioner of traditional Tibetan medicine. The situation regarding amchi medicine in Khumbu not only illustrates changing dynamics within existing medical systems, but also that these can occur independently of the encounter with Western medicine. Oral sources indicate that prior to 1950, Khumbu did not have its own amchi.[21] People going on trading trips to Tibet would buy medicines for various symptoms and bring them back for later use. After the Chinese intensified their presence in Tibet, some amchi came and settled in Khumbu, but patients consulted these less than other practitioners. Some amchi were also lama, and people believed that amchi medicine was empowered through the lama's personal power.[22] Sherpa recognised amchi medical practice as different from their own practice, but because of

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[19] The lama uses dice and books to make a divination and work out a problem through ritual means. He would probably recommend one of many kinds of *pūja* (a Sanskrit term for 'worship' that is widely used by the Sherpa). The *lhawa*, however, is 'transformed' into the offending spirit, which then identifies to those present the cause of the problem and what needs to be done. When there is more than one agent, the *lhawa* becomes each in turn (interview with Ang Rita, Kathmandu, March 2004). Unlike other Himalayan societies, Sherpa *lhawa* do not travel to the world of the spirits (Fürer-Haimendorf 1964: 256).

[20] Interview with Ang Rita, 2003.

[21] Interview with Kami Temba, 1999.

[22] Interview with Ang Rita, 2003. People going on lengthy pilgrimages feared getting sick, and would often carry amchi medicines as well as lama medicine in their *dablam*, which was a shrine-shaped box for protective prints, relics and religious medicine that people wore on a cord and tucked in their clothing. Ang Rita described people taking amchi medicines more on religious faith than for their chemical properties.

their shared Tibetan origins did not perceive it as being as alien, or as different as Western medicine.[23]

WESTERN MEDICINE IN NEPAL IN THE 1960S

At the same time as the establishment and upkeep of Khunde Hospital lay in Western hands, the Nepalese government was also slowly expanding the presence of Western medicine within its borders. Little has been written about the historical development of biomedicine in Nepal prior to the opening up of the country to Western influence and foreign aid during the 1950s.[24] Nepal had neither been colonised nor, except for a brief period during the 18th century, subject to the influence of Christian missionaries. While the Nepalese viewed the new medical system as 'modern medicine', it was not part of a hegemonic colonial process, as was the case in many of the neighbouring regions.

By the mid-1960s, when Hillary was beginning his health programmes in Khumbu, expansion of Nepal's limited biomedical services had occurred in three main directions.[25] Firstly, although most people lived in rural areas, the government generally built more hospitals and clinics in urban areas. Other infrastructural developments included the formation of professional associations, the establishment of a nurse training school, and the creation of the Ministry of Health. Non-Government Organisations (NGOs), such as the United Mission to Nepal, also established their presence in the country as health care providers, again initially through the building or setting-up of hospitals and clinics. The second direction saw the start of an expansion of health services into rural areas, through the provision of family planning and maternal and child health services in selected areas, and the gradual building of health posts throughout Nepal. One of the earlier health posts was established in Khumbu. In 1964, the government opened a clinic which was staffed by two paramedical health workers in Namche Bazar, the small government administrative centre of Khumbu.[26] The

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[23] Interviews with Dr. Kami Temba and Ang Rita, 2003. Adams, however, described similarities between the practice of biomedicine and amchi medicine, and that Sherpa often saw them as the same (1989: 139).

[24] For a brief account see Dixit 1995: 15-29.

[25] Streefland 1985 and Dixit 1995.

[26] McKinnon 1968: 140.

third area involved the introduction of various programmes for the control of communicable diseases, beginning with malaria eradication in 1958, and followed by smallpox, tuberculosis and leprosy during the 1960s.

Generally speaking, as in Khumbu, biomedical services in Nepal neither arrived in a local vacuum, nor necessarily displaced other existing medical systems. Most of the Nepalese population were Hindu, and when sick were more likely to consult Āyurvedic practitioners or a variety of indigenous healers. In contrast to the situation in India at the time, the Nepalese government included both the biomedical and Āyurvedic systems when it established the Department of Health Services in 1933. Modern medicine was seen in terms of Western medicine but, as in India, people preferred their own systems.[27] The Nepalese government also established training institutions for both biomedical and Āyurvedic systems, although in each case the resulting numbers of trained practitioners were small.[28] Their number were also tiny in comparison to the multiplicity of other local healers.[29]

In practice, lack of finance and personnel hampered government efforts to support the implementation of such policies in a poor, rural country that also had an inadequate infrastructure generally. The clinic established at Namche Bazar was little used, and it had difficulty in attracting and retaining staff. When the country's first five year development plan began in 1956, the government had 34 hospitals with a total of just 625 beds, 24 dispensaries and 63 Āyurvedic dispensaries for a population of over eight million people.[30] There were few biomedical facilities in rural areas and most people would have had great problems in reaching any health facility in the first place, given the difficulties of travel within a country of few roads, large rivers and rugged terrain.

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27 Dixit 1995: 23-4.

28 Dixit 1995: 138-9. Between 1934, and the establishment in 1972 of the Institute of Medicine, 512 Ayurvedic personnel of various grades were trained, while 238 compounders and 213 dressers graduated from the Civil Medical School. Doctors were mainly expatriates from Bengal, although some Nepalese were also being trained outside Nepal.

29 A study in 1978 estimated there were between 400,000 and 800,000 traditional healers in Nepal serving a population of around 13 million (Kristvik 1999: 69).

30 Dixit 1995: 45.

MEDICAL ENCOUNTERS AT KHUNDE HOSPITAL

Khunde Hospital was initially Hillary's biggest project and soon became the main provider of health care services in Khumbu.[31] Outpatient and inpatient records provide data on patients, their conditions and their treatments.[32] Rising numbers of outpatients, from a total of 1924 in 1967 to 7224 in 1996, without a corresponding increase in the resident population, indicated that increasing use was being made of the hospital, although the number of inpatients always remained low.[33] The main category of outpatient consultations was for respiratory complaints—both minor and major. Gastro-intestinal problems, ear, nose and throat conditions, skin infections and trauma were also important, while vaccination, injections of iodised oil against goitre, family planning and antenatal care were the main preventive health activities. The hospital also provided inpatient facilities for serious cases, or for people who lived a long distance from the hospital. Initially, there were three beds for the acutely ill and a separate building with eight beds for patients needing to stay longer. Throughout most of its history, the hospital has only had a few inpatients at any given time. Of 2076 inpatients between 1971 and 1997, 13.8% of admissions were related to tuberculosis and 20.9% to obstetrics.[34]

What these statistics do not reveal is the pattern of non-use. This is illustrated, for example, by the fact that in 1985/86, of the 52 deaths known to hospital staff in Khumbu, only one—a newborn with respiratory distress—occurred in hospital.[35] Births and deaths did not have to be officially registered. Consequently, information about both non-use and multiple therapy use has to be gleaned from other hospital documents, or correspondence from the overseas volunteers, and oral

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[31] Hillary built a second, slightly larger hospital at Phaphlu in 1975, which was handed over to the Nepalese government at the beginning of 1980 to become the district hospital for Solukhumbu. Phaphlu is four to five days walk from Khunde.

[32] Outpatient attendances and inpatient admissions are recorded in registers held at Khunde Hospital. This general information on categories comes from the hospital's annual reports. Draper 1995 criticises the hospital for its lack of analysis of the changes that might be occurring.

[33] Seasonal variation occurs in hospital outpatient attendance, largely reflecting the pattern of the Sherpa year. Part of the increase can be explained by a rise in consultations and admissions of non-Sherpa.

[34] The current inpatient register system was started in October 1970.

[35] Khunde Hospital Annual Report, August 1st 1985 - July 31st 1986.

sources. The local Sherpa hospital staff are particularly valuable sources of information about both the current situation and the changes that have occurred. A further important avenue for information is the anthropological field research that has been carried out among the Sherpa since the 1950s, when Christoph von Fürer-Haimendorf first began his work in the area. In addition to ethnographic information and analysis of the Sherpa, the fact that several different studies have been carried out over a long period of time also enables these studies to be used as written historical sources, something which is particularly valuable when dealing with largely oral material. The focus for much of the recent research has become the considerable changes occurring in Khumbu which have been fuelled by increasing tourist activity.[36]

The most detailed research on Sherpa sickness, and healing beliefs and practices, has been carried out by Vincanne Adams and John Draper, who, although concentrating on different areas of Khumbu, both undertook fieldwork during the 1980s.[37] Neither biomedical practice, nor an historical understanding of what was occurring, had been the main concern of the research of Adams and Draper. Both are, in fact, critical of biomedicine, while acknowledging the work of the Khunde hospital. John Draper viewed the hospital as a "highly centralised and somewhat alien institution" for most Sherpa.[38] Adams (1996) discusses the domination of biomedicine in Khumbu and the role of foreign medical aid programmes in modernising the Sherpa. As this chapter demonstrates, however, I believe that Adams research has underestimated Sherpa agency in medical encounters, and thus overemphasised biomedical practice.[39] At the same time, I argue that the overseas volunteers at Khunde Hospital were willing to acknowledge and respect Sherpa beliefs and practices.

The basic question for local people to decide was whether or not to

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[36] See, for example, Fisher 1997. James Fisher first came into Khumbu with Hillary's Himalayan Schoolhouse Expedition in 1964.

[37] See particularly Adams 1989 and 1996, and Draper 1995. Adams also carried out research among Sherpa in Kathmandu.

[38] Draper 1995: 164. Draper was interested in the exercise of power through the control of knowledge and was critical of both Khunde Hospital and the monasteries. Draper died before his Ph.D. thesis was completed and this valuable unpublished work has been largely ignored. In her earlier Ph.D. thesis, Adams also emphasised alien and problematic features of biomedicine for Sherpa. See Adams 1989: 141-55.

[39] See Ortner 2000 for a discussion that emphasises Sherpa agency.

use the hospital's services. If using Khunde Hospital led to a person becoming well, then increasingly people took a pragmatic view and were prepared to give it a try.[40] Their approach, however, was cautious. During 1986 and 1987, Draper collected information on 400 episodes of illness among Thame valley people. Even if, as Draper acknowledged, the five percent who said they used Western medicine was unrealistically low, only seven percent gave it as their preferred choice.[41] A fear of hospital ghosts, especially in the long-stay ward, meant that people were often reluctant to become inpatients. Additionally, not wanting to meet a ghost along the track hinders travel at night to the hospital, because it is believed that an already sick person could be made worse. If the hospital is not going to cure a person then that person still prefers to stay at home. In Sherpa culture it is important to die at home and provide appropriate help for the spirit on its journey, as my initial story shows in the case of the badly injured woman and the expressed wishes of her family to take her home in the case of her death becoming inevitable. Patients are also selective; a successful cure for one problem does not mean a person will then use biomedicine for everything else. Since the opening of the hospital, dealing with trauma has been an important aspect of the hospital's work, while chronic illness has occupied a lesser role.[42] People were generally keen to have smallpox vaccinations, but were not so enthusiastic about other vaccinations. When treatment worked, the hospital's reputation was enhanced, but when treatment was unsuccessful then its position was questioned. The death, around 1980, of a nine day old baby—for which the hospital was blamed—only four days after receiving a penicillin injection, set back the childhood immunisation programme in one village for several years.[43]

The hospital was viewed by Sherpa as just one option in a situation

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[40] Interview with Dr. Kami Temba, 2003. It does not appear to be a problem for the Sherpa to use what might appear to us to be incompatible systems.

[41] Draper 1995: 312-14. Draper did note distance from Khunde Hospital as a factor for non-use, while some people who had only used Western medicine did not tell him about the illness.

[42] These are generalisations. The broad strategy for the use of different therapeutic options was a multiple approach to what helps, rather than being illness specific.

[43] Khunde Hospital Annual Report, September 1st 1983 - August 31st 1984. It was not until 1997 that people in the Pangboche area widely accepted childhood immunisations.

where multiple choices of treatments and medical systems were available and regularly used.[44] The Sherpa word for Khunde Hospital—*menkhang*—translates as 'medicine house' and provides a clue as to how people could use what may appear to others as incompatible systems.[45] People could come to the hospital and receive medicine while still going to other healers.[46] Western medicine was perceived to treat symptoms rather than causes, and so the different systems were considered to have different areas of effectiveness. A comparable situation is described by Martin Gaenszle in his study of the Mewahang Rai of East Nepal, in which he examined the interpretation of illness and the role of the shaman on the one hand, and that of the doctor and health post on the other.[47] Medical knowledge among the Rai, as among the Sherpa, was part of a comprehensive set of beliefs and practices governing all aspects of life. The Rai had incorporated Western medicine into this view by attributing the work of Western medicine to the physical level and the work of the shaman to a metaphysical level. The two were not contradictory: "One eats the doctor's pills but still calls the shaman to ensure that the ancestor deity will be pacified".[48]

While a model of multiple therapeutic options offers a way for different systems to coexist together, a low utilisation of biomedical healthcare facilities does exist in Nepal and also in many other developing countries. Various factors such as staff, clinic times, medicine availability and travel distance, as well as the more obvious issue of cost, can act as barriers to accessing health care. In Tibet during the early 20th century, the British had offered medical services free of charge as a deliberate strategy, both to encourage the use of modern medicine and as an adjunct to their political aims.[49] Until 1982, the services at Khunde Hospital were free for Nepalese residents. Although travel and the costs of staying in Khunde for long periods could create problems for some people, even with a small charge—which was paid

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[44] This continuing use of multiple therapeutic options has been described elsewhere in the region, for example in Ladakh and Rajasthan (Kuhn 1994; Lambert 1997).

[45] Draper 1995: 273.

[46] Ortner Paul 1970: 167.

[47] Gaenszle 1994. The number of non-Sherpa patients has increased throughout the hospital's history and many of these are Rai who have come to live and work in the district, particularly the adjacent and lower area of Pharak.

[48] Gaenszle 1994: 56.

[49] McKay 1997: 168.

for in cash and has approximately equated to the price of a cup of tea bought locally in a lodge or teashop—biomedicine in Khumbu has usually been cheaper than the alternative local systems. The nil or low cost of services and medicines at Khunde Hospital, however, could also work against it. During her field research among the Sherpa of the Solu area in the mid-1960s, anthropologist Sherry Ortner wrote that when she gave out medicines brought back from Khunde Hospital many people insisted on paying for them as otherwise, it was believed, they would not be effective.[50] Nima Yangen, who came from Khunde, and who was the first assistant nurse at the hospital, described that when people went to the capital Kathmandu and discovered how expensive such medicine was, they started using Khunde Hospital and its medicines more precisely because they knew that they were expensive.[51]

The hospital staff in their turn had to respond to the way local people were or were not using their services. Working among the Rai people, Gaenszle observed the different medical systems as co-existing, but also identified areas of conflict between them. Ideologically, 'meaning' for the Rai derived from their indigenous belief system, and thus on these terms Western medicine had no authority. At a practical level, there could also be problems of cost and practical issues, such as where to stay, since the government health posts in the Rai area—unlike Khunde Hospital—usually had no accommodation facilities.[52] Lastly, the situation was made worse because the representative of the health post often came from another ethnic group, and could even be a high-caste Hindu whose rules for social interaction were different. Gaenszle concluded that if these problems were minimised, and trust and respect existed between villagers and the health post staff, then "a certain harmony can be achieved".[53] This situation did develop in the case of Khunde Hospital.

Volunteer doctors at Khunde Hospital could have chosen to ignore local scepticism or lack of interest by the Sherpa, but this was not the case. McKinnon, the first doctor, took various approaches. While he tried bringing patients into the hospital, he also went out into the villages to take care of patients closer to their homes.[54] He talked with the

[50] Ortner Paul 1970: 103-4.

[51] Interview with Nima Yangen Sherpa, Kathmandu, July 2003.

[52] Patients, and their family members who helped look after them, still had to meet the cost of food at Khunde Hospital.

[53] Gaenszle 1994: 59.

Rinpoche of Khumbu's main monastery at Tengboche about the acceptability of family planning.[55] Dr. Richard Evans, who succeeded McKinnon towards the end of 1968, altered the treatment schedule for tuberculosis to try and make it more suited to the Sherpa lifestyle.[56] His successors, Drs Selwyn and Ann Lang, during their two years at Khunde in 1970-71, tried to explain biomedicine through health education talks.[57] Gradually, the overseas volunteers learned what was popular and what was not, or who would come and who would not, and when and for what, and how to prescribe medicines so that people would take them appropriately.

Nevertheless, the volunteers could become frustrated and upset at times, particularly when they believed they could have helped someone who had died in the community, or when something occurred that appeared senseless or insensitive. One such occassion was in 1984, and concerned the destruction of a large number of doses of measles vaccine by children in the village.[58] The vaccine had arrived from UNICEF in Kathmandu months too early for the following year's vaccination program, and in the monsoon period it presented considerable storage problems. The only place cold enough to hold it in storage was in the bucket in the water pipe intake located on the ridge behind the hospital. However, when Khunde doctors Keith and Elly Buswell went to check it a few days later they were 'horrified' to find only 18 of the 50 vials left. In a letter back to New Zealand they described how they were

> pretty upset about the whole thing, firstly because we didn't want the vaccine sent in the first place, and secondly because the kids here would want only [to] destroy the vaccine, while surely knowing it belonged to the hospital.[59]

Persuading patients to return for follow-up monitoring or treatment

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[54] Interview with Nima Yangen, 2003; McKinnon 1968. Coercion has not been a feature of Khunde Hospital practice and the hospital was not in a position to insist on compliance.

[55] Interview with McKinnon 1997. Some confusion must have occurred, because while McKinnon thought there were no constraints, local people were less keen because they viewed family planning as 'sinful'. Interviews with Nima Yangen, 2003, and Dawa Phuti Sherpa, Lukla, June 2003.

[56] Letter from Dr. R. Evans to Dr. C. Allenbach, Jiri Hospital, 20 July 1969.

[57] Khunde Hospital Annual Report, November 1st 1969 to October 31st 1970.

[58] Letter from Drs K. and E. Buswell to Dr. M. Gill, 22 June 1984.

[59] *Ibid.*

has been a recurrent problem throughout the hospital's history. Tuberculosis could be cured, but has remained a difficult disease for the hospital to deal with. The length of treatment is now six to eight months rather than two years, but is still too long for easy compliance. Ang Pasang, who worked at the hospital as an assistant from 1970 to 1979, describes how people disliked taking the large brown tablets—one was hard enough to swallow but people had to take several at a time.[60] Annual reports frequently noted patients refusing treatment. Attempts were made to encourage attendance or treatment compliance through examples of people who had been cured, health education talks, or by enlisting the support of the Hospital Advisory Committee or the local district committee. Both oral and written sources, therefore, give evidence of the limitation of the overseas doctor's position, and also that of biomedicine in the area, and show that the doctors were very well aware of this limitation. Adams attitude is critical when observing the doctors in the clinic at Kunde Hospital dealing with patients who had defaulted on their tuberculosis treatment. However, I believe it is better to understand this in the context of the doctors' awareness of the limitations of their position, rather than her overall argument about the domination of biomedicine.[61] Some patients will go away dissatisfied from the medical encounter, but so too do the doctors who, in the two years they spend at the hospital, form an intense relationship with the local people and the area.

Childbirth was another area where the Hospital staff has encountered resistance.[62] There are no midwives in Sherpa society. In the past, women delivered their babies at home, either alone or with the assistance of their mother or sister. The important consideration for the person assisting was that it should be someone who had 'good thoughts' about the woman, and not someone who might harbour 'bad thoughts' which could bring problems.[63] People also liked to keep quiet when a delivery was imminent to avoid attracting the attention of pem or nerpa which again could bring trouble. Among Sherpa, it remains desirable today for a woman in labour to avoid being seen by another woman who might harbour ill thoughts that could result in the birthing mother hav-

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60 Interview with Ang Pasang Sherpa, Lukla, June 2003.

61 Adams 1996: 97-8.

62 Also see Adams 1996: 106-7.

63 Interview with Ang Rita 2004.

ing a difficult labour, or even having her male foetus turn into a female one.[64] This belief, however, does not apply to the female overseas doctors at the hospital. Traditionally in Sherpa society, birth has been a highly polluting event in which men were not involved. But today, men —either the husband or hospital staff—may be involved, both at home and in hospital, even helping with the cleaning up. Ironically, male Sherpa hospital staff can be more acceptable than female. Yet even in the past, the husband could be involved if the woman was really in need of help and there was no appropriate close female relative available.[65]

The doctors viewed it as good medical practice to encourage women's attendance for antenatal care and to have their babies in hospital. In their analysis of the first five years of the hospital's work, the Langs reported that of 74 women who came in for antenatal care only nine subsequently delivered their babies at the hospital.[66] The total number of births in the area is not known, but during this period the hospital was involved in 25 deliveries, of which 11 were in hospital and 14 at home. Distance was one factor in the decision to have a baby at home: six of the domiciliary births were in the more distant village of Thame, although five were in Namche Bazar which was only one hour's walk away, and two were in Khunde itself. Whatever explanations may be offered, babies in any case are notoriously unpredictable in announcing their impending arrival, and this makes planning difficult. Hospital staff do try to encourage women to deliver at the hospital, especially when problems are picked up antenatally, but they respond to requests for assistance at home. Of the 14 home deliveries between 1967-71, the doctors considered eight to be complicated. While the number of babies born in hospital has increased—and particularly those from the villages nearest the hospital—this pattern of hospital response to requests for assistance at home has continued. A demographic survey for the five year period 1998-2002, which was recently carried out by the hospital, includes the total number of births in the area and shows that most births are still at home, although at a lower level than the national average.[67]

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64 Participant observation of cases of childbirth during the two year period 1996-98.

65 Interview with Ang Rita, 2004.

66 Khunde Hospital Annual Report for the Year Ending 31st October 1971—including an Analysis of Cases for the First Five Years (1967-1971).

67 I am grateful to Dr. Kami Temba for letting me see the provisional results of his

Khunde Hospital and the Local Community

While part of understanding the nature of medical practice at Khunde Hospital lies in the medical encounter, and the meeting of Sherpa beliefs and practices with those of Western medicine, part also relates to the role played by the local—mostly Sherpa—staff and the wider relationship between the hospital and the community.

Local personnel have played a key role in educating not only the overseas volunteers about living and working in Sherpa society but also the patients about being at the hospital. The small number of staff know the community well and guide the volunteers through their time at the hospital, advising on the myriad issues that affect both medical and social aspects of being at Khunde. The hospital, for example, uses three types of calendars—Tibetan for Sherpa affairs, Nepalese for matters related to life in Nepal, and the Western calendar reflecting the hospital's position as a foreign aid project. Immunisation is carried out as part of the Nepalese government programme and is held monthly according to the Nepalese calendar, while in 1998 the building of a new clinic was delayed for a whole year because, according to the Tibetan calendar, the time was inauspicious. In the example of the missing vaccine which was discussed earlier, the doctors wrote in a letter back to New Zealand that they "were furious and started going around the village looking for it", but Hillary's sirdar, Mingma Tsering, "decided that it would be best if he took over and did so".[68] The culprits were found and the situation resolved in a satisfactory local way that did not reflect badly on either the volunteers or the hospital. The local staff also have to assist patients in what can be a very unfamiliar situation. The hospital, for example, has had electricity since late 1994, but some inpatients come from areas without it, and so staff need to show them how to use electrical equipment, such as the small cooking stove, to facilitate their stay at the hospital.

While the Western volunteers at Khunde Hospital changed generally every two years—with each couple needing to be introduced into the local cultural setting—there has been considerable local staff stability since 1980.[69] Kami Temba was first employed as a village health work-

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demographic survey which was carried out for Khumbu and the adjoining area of Pharak.

[68] Letter from Drs K. and E. Buswell to Dr. M. Gill, 22 June 1984.

er in Thame in 1976, before starting work at Khunde Hospital the following year. In 2002, he became the first Sherpa doctor in charge of Khunde Hospital. Mingma Temba began working at the hospital early in 1979 and continues today, working both in the clinic and acting as hospital manager. Local staff and volunteers have worked together closely, with the staff generally acting as interpreters in both medical and social settings. Relationships have varied according to the people involved at any one time. Until more recently, volunteers usually have been young and fairly recently qualified. In the early years of the hospital, they often developed good language skills, yet today less so, not only because the local staff have developed both their medical and English language skills, but also due to the increasing level of English that is spoken by the local community. The Sherpa staff have learnt how to translate between language and culturally conditioned medical concepts in both English-speaking and Sherpa worlds. They became enormously important mediators for the hospital and the local community. A large part of the hospital's and volunteers' success is due to their abilities.

From the beginning, the hospital has also had a wider role than just health care. Although volunteers have acted in liaison or representative roles for the many other Himalayan Trust projects in the area, the hospital has not tried to run the community.[70] Hillary's general way of working has been to respond to requests from local people, and he believes that it is important to involve local people in the implementation of a project, rather than the other way round, which is a common feature of many foreign aid projects. Early volunteers also taught English to children at Khumjung School or to adults at the hospital. People have come to the hospital to collect mail that has arrived from Kathmandu with the hospital's mail runner, collect scholarships or other financial payments related to other Trust projects, or in more recent times, to use the telephone. The uneven existence, however, of the Hospital Advisory Committee has been a less successful area. The

[69] The Himalayan Trust has found that a couple in a stable relationship has been an important factor in the overseas volunteers having a generally successful time at Kunde Hospital.

[70] There have been a few occasions where volunteers are thought to have overstepped the unspoken boundary. One case involved making an example of Hillary's sirdar and friend, Mingma Tsering, over the cutting down of some trees. Volunteers run the risk of upsetting the local people, the Himalayan Trust or in particular Hillary.

hospital, which was built on land available at the edge of the village of Khunde, and the 'hospital family' as a whole have been given a place within the community. Local staff also have their own individual position within Sherpa society, and so it is important for the hospital's acceptance that staff are socially suitable and, since home visits invariably involve cups of tea, can participate in Sherpa hospitality. The hospital family attends Dumje, but does not have the responsibility of financially sponsoring the event, while at Losar, i.e. Tibetan New Year parties, the hospital is expected to take its turn at hosting. Yet the hospital's position is also fluid. This is perhaps seen best in the different seating positions given to the hospital family when attending a gathering.[71] Above all, the relationships between the overseas volunteers and the staff and patients from the community, as with Hillary and the Himalayan Trust in general, have been characterised by friendship and respect.[72]

Conclusion

When Khunde Hospital first opened at the end of 1966, the young overseas doctors were confident about the benefits of their Western medicine, and did not expect the cautious response that greeted many of their efforts. Biomedical services in Nepal at the time were limited, and in remote areas such as Khumbu often non-existent. Khunde Hospital, nevertheless, did not enter a vacuum. The local, mainly Sherpa population had their own beliefs and practices about what to do when sick, but did not see that these were necessarily in competition with the new ideas and system. The number of patients at the hospital has increased considerably, but people's use of the hospital has been pragmatic and

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[71] Ortner Paul 1970: 316-21. Seating arrangements are an important part of Sherpa ritual and expression of social hierarchy.

[72] Hillary has referred to the Sherpa, for example in, *Schoolhouse in the Clouds* 1964, as 'unsophisticated', but this should not mask the true nature of his relationship with the Sherpa people, which is based on friendship and respect among equals. Words such as 'unsophisticated', however, were often used in mountaineering accounts at this time and were located in discussions or observations of the 'unmodern Other'. Writers saw both strengths and weaknesses in the Sherpa. Hillary's first autobiography in 1975 was full of such references. The climbers also tended to reject the routine and boredom of their own modern life. Ortner, in discussing the '*sahibs*' of Himalayan mountaineering, also refers to the values of male, Western paternalism of responsibility towards the subordinate and weak (Ortner 2000).

selective. As a result, the doctors soon became aware of the limitation of their position, and that of biomedicine more generally. The medical encounter, however, was only part of understanding the nature of medical practice at Khunde Hospital. The local, mainly Sherpa staff occupied an important mediating role between the hospital and the community, and between also the overseas volunteers and the community. These relationships extended beyond matters relating to health care, and led to Khunde Hospital developing a key position in the life of the local community.

After 38 years, Kunde Hospital and the Sherpa community have become accustomed to one another. The event of an illness that leads to an encounter with Khunde Hospital is negotiated, therefore, in a multilayered context that reflects many factors. It is not a question of Sherpa beliefs or Western medicine but how Sherpa beliefs and practices and Western medical practice in Khumbu have found a way to exist together. Returning to the story at the beginning of this article, what was being practised was still biomedicine, but in a situation where Western medical services were provided from Khunde Hospital in a context that acknowledged—not only through the medical encounter but also through the hospital's wider role within the community—a general spirit of trust and respect. It is through this spirit of trust and respect that Sherpa beliefs and practices can be maintained in medical and other encounters with the Khunde hospital.

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Plate 1: Khunde hospital

PART TWO: TRANSMISSION, PROFESSIONALISATION, AND ISSUES OF IDENTITY

BON LINEAGE DOCTORS AND THE LOCAL TRANSMISSION OF KNOWING MEDICAL PRACTICE IN NAGCHU

MONA SCHREMPF

The physician without medical lineage,
Like the fox who seized the royal throne,
Is not able to gain everyone's respect,
And even if respected, cannot hold the kingdom down.[1]

INTRODUCTION

This saying from the standard Tibetan medical text, the *Rgyud bzhi*, was cited repeatedly to me by several senior lineage doctors in Nagchu (TAR) when asked about the particularities of medical knowledge through the transmission by lineage. It may also indicate the social importance of respect and trust invested by patients in the status of a 'lineage doctor' (*sman pa rgyud pa*).[2] Furthermore, the fact that the lineage doctors interviewed were senior and Bon po, and were practicing mostly inside their communities, might play a considerable role in the way they perceive themselves and were perceived by their patients in terms of transmission of, and trust in local medical knowledge and practice.[3] As Dondrup Lhagyal has pointed out, in the Bon religion "the family lineage, rather than spiritual succession from master to disciple, was considered important".[4] In this chapter, however, lineage is under-

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[1] Plate 1, see overleaf. Source: Gyurme Dorje *et al.* 1992: 90. *Sman rgyud med pa'i sman pa de / wa yi[s] rgyal sa bzung ba bzhin / kun gyis spyi bor bkur mi nus / bkur kyang rgyal sa non mi 'gyur*. This saying is written down in the *Explanatory Tantra* (*Bshad rgyud*) of the *Four Tantras* (*Rgyud bzhi*), in the 31st chapter which deals with the qualities of a doctor (*sman pa'i le'u*).

[2] *Sman pa* was the colloquial term for Tibetan 'doctor' used by all my informants throughout Nagchu. *Sman pa* is also customarily used in Amdo dialects, whereas 'amchi' is common in Lhasa and Southwestern Tibet, as well as in the Himalayas (India, Nepal) and in Tibetan exile.

[3] My informants repeatedly stressed that their religious affiliation would play no role whatsoever in their practice or their patients' choice to be treated by them.

[4] Dondrup Lhagyal 2000: 429. This author demonstrates that from the 10th century onwards, five Bon family lineages from Central Tibet became crucially important as lama lineages, in the establishment of monasteries, and thereby laid the foundations in different areas for the continuation of their socio-political influence and Bon monasticism.

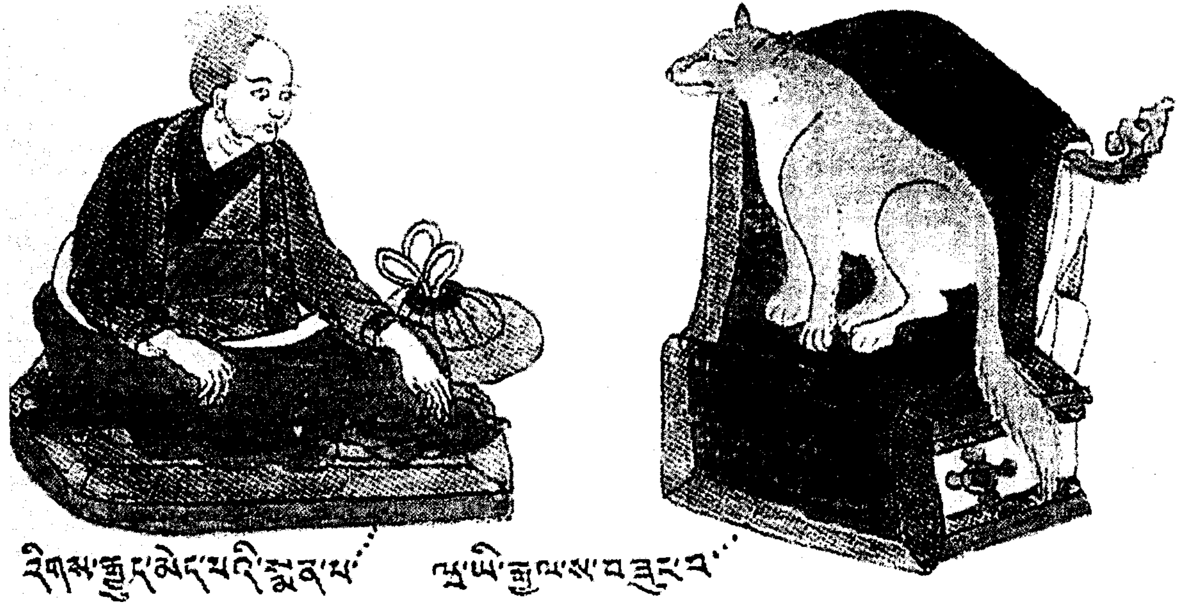


Plate 1: The fox-doctor as illustrated in the parable in the *Rgyud bzhi*

stood as being a transmission by way of both family and from master to disciple. In accordance with the *Rgyud bzhi*, my doctor informants themselves differentiate between 'real' medical family lineages and lineages characterised by master-apprentice relationships—usually giving preference in status and authority to the former, as indicated in the saying above. What seemed to be of particular importance in this respect was their personal apprenticeship with their teachers starting from an early age. By emphasising the particular knowledge and achievements of their teachers, which they in turn identify with and transmit to their sons and students, they explicitly set the lineage model apart from the dominant state medical educational system epitomised by the Lhasa Mentsikhang, and the increasing modernisation and standardisation of Tibetan medicine, which has been taking place during the past 50 years. The present study will demonstrate how local doctors use lineage to legitimise themselves as upholders of a medical tradition inside their former tribal communities in the nomadic region of Nagchu, and how it also reflects and legitimises regional medical expertise. This medical expertise, in addition to the general transmission of the standard medical knowledge as expounded in the *Rgyud bzhi*, concerns the personal transmission of specific medical treatments and local medical knowledge, especially concerning *materia medica*. Since we are still at the very beginning of our research into these personal and local forms of Tibetan medical knowledge and practice—even in terms of their historical dimensions—this preliminary study aims to raise awareness of the existence, particularity and social relevance of localised Tibetan medical knowledge as transmitted through lineage, and also some larger questions regarding the transmission of medical knowledge in general. I will also try to expose the familial, social and professional relationship among these lineage doctors, and reveal an alternative model of Tibetan medicine that can either exist outside of, or overlap with, institutionalied and modernised Tibetan medicine represented by the Mentsikhang system. The most important social factor of privately practising and knowledgeable local Tibetan lineage doctors is that they are able to fill the gaps in the current public health system by providing free health care with locally produced medicines for needy patients.

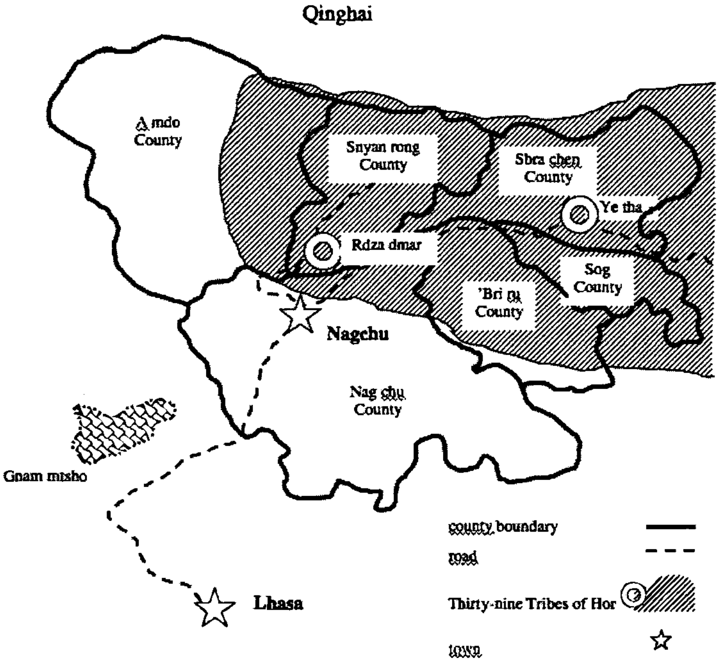
Studies on contemporary Tibetan medicine in the TAR have mainly focused upon the Lhasa Mentsikhang and similar institutions. We still know little about the history of the transmission of 'knowing practice' (Farquhar) outside those institutions—something we could perhaps call

'Tibetan medical subcultures'. This concerns, especially, personal and local medical knowledge acquired orally and through a physician's clinical experience, but it also entails popular lay knowledge of medicine. It concerns medical knowledge that also exists largely outside of the realm of medical histories, royal courts, monasteries and the biographies of important masters. Of course, Tibetan and other medical histories are known to us primarily through written texts, and since "Tibetan histories are more commonly histories of literary production", medical histories tend to define and describe lineages in terms of their transmission of certain medical texts.[5] One way, and possibly the only way, out of this dilemma is to undertake ethnographic fieldwork together with knowledgeable senior professionals and to inquire about local histories of medical practice and lineages by way of oral historical methodology.[6]

The preliminary data discussed herein was collected on the basis of biographical interviews and participant observation of medical encounters with eight, mostly senior, lineage doctors, working both within and outside of the state medical system in Nagchu Prefecture, namely in the three administrative units of Nagchu County, Sbra chen County and Snyan rong County during autumn 2003 (see Map). The majority of my informants were highly respected senior lineage doctors, mostly over 60 years of age. Coming from Bon po communities, they all believe in the Bon religion, which is why, when asked, most identified themselves as 'Bon doctors'. However, they did not stress their Bon identity in any other way. Instead, they emphasised their lineage affiliations with knowledgeable teachers, among whom there also exists a minority Buddhist component.

[5] Garrett 2004: 174. Thus, our knowledge of the history of medical lineages is very much focused upon the two famous medical schools of Zur lugs and Byang lugs which are referred to in medical histories, such as the *Khog 'bugs* by Desi Sangye Gyatsho and the *Thob yig* by Jaya Paṇḍita, in which uninterrupted lineage transmissions over several centuries are claimed (Taube 1981). Especially from the second half of the 17th century onwards, Buddhist monasticism had a strong influence on the institutionalisation of Tibetan medicine until the more secularised Lhasa Mentsikhang was established in 1916.

[6] Data gathered during fieldwork by oral historical methods represent the main body of this article. Yet, the findings need to be more widely compared with other medical landscapes in the TAR, as well as with textual sources. The latter, though scarce, are merely referred to here and remain to be explored in detail.



Map: Research areas in Nagchu Prefecture, TAR

The Power of Lineage in Medical Transmission

'Lineage' (*rgyud*) implies an unbroken and (life)time transcending continuity, ensuring not only the transmission of 'bone' (*rus*) substance, inheritance, status and authority within a family or clan, but also often certain types of specialist or professional knowledge. Whether from teacher to student, (grand)father to (grand)son, or 'uncle to nephew' (*khu dbon*)—the latter mode of succession being a characteristic pattern in Bon po religious communities—lineage is the traditional backbone of all types of professional knowledge in Tibetan culture, extending backwards through time much further probably than any other social institution. Being a lineage member legitimises the person and his or her craft, linking and bestowing the reputation of the previous famous lineage holders who are remembered and venerated, onto present (and future) holders. This process links together past with present, the member of a lineage with a sequence of teachers and students, and persons, specific texts and certain important places, as exemplified in Tibetan historical and biographical literature. Thus, Garrett points out the importance of lineage that characterises and defines both the individual and the group: "Tibetan medical historical and biographical literature clearly adheres to this genealogical model of narrative self-identification".[7] The standard text of Tibetan medicine, the *Rgyud bzhi*, is no exception. Two principal figures are made responsible for its transmission and redaction, G.yu thog Yon tan mgon po the 'Elder' and the 'Younger', followed by various lineages, of both the family and the master to disciple type of transmissions.[8] And even though many Bon doctors are taught on the basis of the standard 'Buddhist' text of the *Rgyud bzhi*, they also receive an alternative view of the history of Tibetan medicine based upon Bon historiography and exemplified by their own medical text, the *'Bum bzhi*. This Bon historical perspective is crucially important in terms of their identity, and it will be discussed in more detail below. More importantly, they identify with their own teacher's medical expertise and achievements and with the oral history of their lineages.

In general, a traditional Tibetan medical education can be obtained in three ways. In the first case, a local doctor in residence can pass on

[7] Garrett 2004: 179.

[8] More detail can be found in Meyer 1992: 3f.

his knowledge to his sons, relatives and/or chosen students in privately organised groups—this represents what I call the lineage model of transmission introduced above. Secondly, a would-be doctor can enrol at one of the rare Tibetan Buddhist schools of medicine, such as at Sku 'bum monastery in Amdo. Third, one can become a student at a state medical school, such as the Medical College or the Mentsikhang in Lhasa. As we will see, these modes of acquisition and training do not necessarily represent mutually exclusive ways of learning, since both teachers and students can, and do, combine them through particular patterns of teaching and study.

Even though state medical institutions might employ teachers coming from medical lineages thereby cutting across private lineage and centralized institutional frameworks standardised school curricula inevitably streamline medical knowledge according to state policies and a prevailing pressure to 'scientise' and secularise their curricula (see Adams and Craig this volume). As explained by my informants, such streamlining and scientising trends also mean that students of state medical institutions obtain less clinical practice and practical knowledge of medicinal plants than their colleagues who are taught privately in small study groups.[9] In other words, even though medical knowledge —even among lineage doctors—is both transmitted through the legitimising and standard medical text of the *Rgyud bzhi*, and supplementary oral commentary by teachers, it is especially the personal experience of having a close working relationship with a knowledgeable teacher and his transmission of medical and pharmacological practice that is considered to be of most importance. The ideal medical teacher is considered to be one who is trusted by the local community and who is situated in the locality. He should have a very good knowledge of the local environment and its medicinal plants and minerals. He should be connected to a network of providers of other medicinal herbs with whom he will exchange in order to complement his own stock of *materia medica*. The local population may tend to have more trust in medical knowledge transmitted in this traditional way because it is perceived as being less influenced by state health policies and 'Chinese' or 'party medicine' (*rgya sman* or *tang sman*)[10] and that it therefore

[9] See Craig, this volume.

[10] See the short discussion on the terminology of Tibetan medicine in the Introduction to this volume.

retains and transmits a more extensive diversity of traditional Tibetan medical knowledge and practice today.

INDIVIDUAL, MEDICAL AND RELIGIOUS IDENTITIES AND PRACTICES

When asked about their religious identities, Bon doctors from Nagchu made a strict separation between their personal belief in the Bon religion and their professional work as doctors. They emphasised that there is no such thing as a specific 'Bon medicine'—except for the explicitly Bon po historiographical notion that Tibetan medicine originated in an earlier Bon medicine before the later Buddhist version of Tibetan medicine became dominant.[11] Yet, contrary to what one might expect, the *'Bum bzhi*, the text which represents the standard medical work in Bon, has not been used among these Bon lineage doctors in Nagchu.[12] This fact did not seem to worry them at all, since they pointed out that the *Rgyud bzhi* would be in any case the younger redaction of the older *'Bum bzhi* text, whose archaic Zhang zhung terms are too hard to understand and not in general use any longer.[13] Prior to the 1960s, even

[11] Many recently published works on Tibetan medicine, especially inside China, but also increasingly in Tibetan exile (apart from some strictly Buddhist versions of Tibetan medicine), have accommodated the Bon po version of Tibetan medical historiography (for more details see footnote 13). Additionally, 'Bon medicine' has become the subject of Bon po scholarly discussions depicting it as the ancient form of Tibetan medicine (Namkhai Norbu 1995, Menri Trizin Lungtok Tenpai Nyima 1998, Dbra khyung dge bshes skal bzang nor bu 2000).

[12] Millard, in contrast, stresses the importance of the *'Bum bzhi* used as the main educational text in the Tibetan Bon medical school at Dhorpatan, Nepal (2002: 33). However, since both *'Bum bzhi* and *Rgyud bzhi* are basically identical, he also states that "it makes little difference whether the students study the Bumshi or the Gyushi, and indeed both texts are studied at the school" (2002: 35). In any case, like the Bon lineage doctors from Nagchu, the main teacher of the school, the lineage doctor and Bon po lama Amchi Gege, who comes from a medical family lineage in Kham, used to study Tibetan medicine on the basis of the *Rgyud bzhi* (Millard 2002: 27ff).

[13] According to the explanations of several senior Bon lineage doctors, the *'Bum bzhi* represents one of few genuinely old Bon medical texts that are still extant today. Most of these texts belong to the Bon *gter ma* literature. Thus, I was told that the famous *gter ston* Khu tsha zla 'od (b. 1024) rediscovered Bon medical texts in Spa gro phug gcal (see also Karmay 1972: 146, fn.3, with reference to text titles). For a discussion on the origins and main chapters of the *'Bum bzhi* (alias *Bdud rtsi bang mdzod 'bum bzhi'i mdo*) as part of the Bon po *Bka' 'gyur*, with its own partly controversial *gter ma* traditions, see Martin, Kværne and Nagano (2003: 107–23; and text no. 144 in the *Mdo* section). For a reproduced version of the *'Bum bzhi* text see *Gso rig bdud rtsi'i bang mdzod 'bum bzhi* 1999 in the bibliography below. I have been told by a Bon lineage doctor that originally there were two major *gter ston* traditions of the *'Bum bzhi*,

the text of the *Rgyud bzhi* was already hard to obtain in rural areas, and Bon doctors used whichever versions of the text that were available. Nevertheless, for the Bon po, the *'Bum bzhi* still maintains its historicised and symbolic value as the 'original' Tibetan medical text. Part of their legitimation is to point out the many Zhang zhung terms in Bon and even in Buddhist medical texts believed to be remnants of an original medical system from the land of Zhang zhung,[14] thereby reinforcing the earlier history of Bon in comparison to the later introduction of Buddhism to Tibet. Therefore, the Bon po view is that the origin of the Tibetan medical tradition is associated with the origin of Bon religion and attributed to Dpyad bu khri shes (literally 'The One Who Knows Ten Thousand Diagnostic/Treatment Methods'), who had learnt it from his father, Ston pa Gshen rab, the founder of Bon religion, and had passed on his knowledge in medical lineages and through *gter ma.*[15] It seems that most modern historiographies on Tibetan medicine, especially those published in China, do acknowledge Dpyad bu khri shes as the first expounder of Tibetan medicine.[16]

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being that of the aforementioned Khu tsha zla 'od, and another related to Gshen chen klu dga' (996–1035). The latter had passed the text on to Dge slong kun dga'(dates?). G.yu thog the Younger then transformed the *'Bum bzhi* version found by Gshen chen klu dga' into the *Rgyud bzhi*, which is how the Buddhist line of the *'Bum bzhi* originated. (Dan Martin, in personal communication, strongly rejects such a possibility, since there are no known sources on or by Gshen chen klu dga' to support such a claim). The other text, that rediscovered by Khu tsha zla 'od, is claimed to have been used by generations of Bon doctors up until today, that is, at least ideally, since the actual practical use of the *'Bum bzhi* as the main medical teaching text must have been generally very rare due to its lack of availability. At least one copy of the *'Bum bzhi* is known to have existed at Sman ri monastery in Gtsang (see Millard 2002: 35).

[14] Karmay (1998a) discusses the different debates and traditional points of views among Buddhist scholars regarding the origins of the *Rgyud bzhi.* Additionally, he refers to the Bon po point of view presented in an important medical commentary by Khyung sprul 'Jigs med nam kha'i rdo rje (1972) which, despite its generally synthesising character drawing on both Bon and Buddhist medical sources, claims that the *Rgyud bzhi* was originally written in Zhang zhung language. Furthermore, Karmay points out that at least one Dunhuang document (PT 127) mentions the existence of a Zhang zhung medical tradition (1998a: 231).

[15] Karmay 1972: 24. See also Millard 2002: 20f.

[16] Thus, in a recent chronologically ordered compilation of biographies of Tibetan doctors and medical scholars, Drang srong Dpyad bu khri shes is the first to be mentioned (Byams pa 'phrin las 2000: 7–12). See also Pasang Yontan (1989); compare with Rechung (1973: 14), who does not refer to the existence of a pre-Buddhist Bon medicine. See likewise the representation of Tibetan medicine by the Dharamsala Tibetan Medical and Astro Institute of H.H. Dalai Lama, which begins the history of Tibetan medicine with Khri Srong lde bstan (http://www.tibetan-medicine.org/history.asp). None of these discussions, however, inform us of the actual history of Tibetan medical texts, such as the *'Bum bzhi* and the *Rgyud bzhi*, about which different stories of origin exist. A detailed comparative analysis of both texts is still awaiting scholarly attention.

In addition to their collective identity as members of Bon medical lineages, the Nagchu lineage doctors all appeared to be rather individualistic. For example, apart from their immediate family members involved in medicine, they hardly referred to each other during interviews, even when questioned about their local colleagues. At the same time, they are also very conscious of their former tribal affiliations, including the history of medical practice within each tribal area.[17] Upon further investigation, it turned out that many of them came from the same former tribe, now a *rdzong* or county level administrative region, and they had shared the same teachers there, though they had not necessarily learnt the same things at the same times. Some of these former students were either distantly related to each other and/or were related to their teachers. Even though few of them have become renowned because of a specific medical expertise transmitted to them by an individually chosen teacher, these lineage doctors also share quite a remarkable pool of common teachers and their special treatments—mainly external ones—such as 'blood letting' (*gtar*); 'moxibustion' (*me btsa'*) and the administration of 'purgatives' (*bshal*). These practices, so I have been told, are rarely used—if at all anymore—at the Lhasa Mentsikhang. As I will show below, the construction of medical identity among the Nagchu lineage doctors is based, first and foremost, upon their teaching lineage and the different medical expertise they learnt from their teachers or developed by themselves, but also on their regional or tribal affiliations. The latter has to be understood in historical and political terms as generally being antagonistic towards, or at least deeply suspicious of, Lhasa as the centre of political power, be it the former Dge lugs pa dominated Central Tibetan state or the present regime. Additionally, one should keep in mind the different social systems of Tibetan nomadic and farming societies. Furthermore, in contrast to Lhasa Mentsikhang practice, several rural lineage doctors, especially those who practice privately, actually produce their own medicines and shun those that are produced in factories (again especially those produced in Lhasa factories which are generally not trusted). The private doctor's medicines are a mixture of locally gathered herbs, minerals and animal products, supplemented with non-local ingredients

[17] This was true to the extent that some doctors from Snyan rong region claimed that 'Bri ru County had no doctors of traditional Tibetan medicine, a claim that turned out to be untenable.

that they trade from suppliers. These medicines are believed to be particularly efficacious and are very highly sought after, even among the urbanised population.[18] Such specific medical expertise distinguishes lineage doctors from each other. On the one hand, the private production of medicine empowers private doctors to be independent, whereas Mentsikhang lineage doctors have no choice but to prescribe ready-made medicines that have to be purchased at Mentsikhang pharmacies. On the other hand, private doctors have the choice—and at the same time the financial burden—of giving medicine for free to their poor patients. Additionally, what distinguishes lineage (and other) doctors of Tibetan medicine from one another are their differing inclinations and relationships to their teachers, for example, a closer, more intense and comprehensive, more direct relationship, starting to learn at a very young—i.e. earlier—age, and being more specialised in a certain area, or a choice of additional teachers with specific expertise.[19] This, however, seems to contradict their similar educational history and legitimation, i.e. the fact that they share common teachers and/or family ties, and that they distinguish themselves from learning/teaching by way of a state medical curriculum. It could be argued then, on the one hand, that lineage (i.e. the main teachers and their medical expertise) legitimises a doctor's medical knowledge and practice in a traditional sense and thus represents a significant Tibetan cultural value and status acknowledged by their communities. On the other hand, what might fuel doctors' individualism is the fact that they share the same patients and thus are in competition since they live and practise rather close to each other, either in the same town, as in Nagchu, or as neighbours in the same nomadic area. This might also produce an inclination to specialise in the treatment of different diseases. In the end, even though they partly shared the same teachers, family lineage doctors would definitely identify with their family lineage and teachers rather than with

[18] I incidentally witnessed the well-attended visit to Nagchu town of a rural doctor who is famous for producing his own medicine. Despite the fact that the Nagchu Mentsikhang owns a well-stocked medical factory, patients flocked to this doctor and stocked up on his self-made Tibetan medicine.

[19] These issues do not exclude the fact that such personal transmission of particular medical practice also occurs inside state medical institutions where certain aspects of lineage transmission still operate on unofficial levels. For interesting comparative data on Chinese lineage doctors, and plural ways of learning Chinese medicine today and in the past, see Scheid (2002: 168ff). See also his example of a personal transmission of a needle technique between a medical teacher and his modern 'disciple' within the context of institutionalised medical practice (Scheid 2002: 40f).

their non-related teachers, even though the latter might have been more famous. Members of a master-apprenticeship would, naturally, stress their most famous teachers, especially if they continued to practise the specific treatments for which their teachers were renowned. Seniority among doctor brothers and cousins was another important factor in terms of the acquisition of knowledge, identity construction and social status.[20]

In addition to the above-mentioned elements of lineage and personal identity construction, professional ethics—again cited directly from the *Rgyud bzhi*—plays a major role in the self image and legitimation of senior Bon lineage doctors. Proper ethical behaviour consists of compassionate action towards the patient, the leading of a healthy lifestyle free from the use of alcohol or tobacco, and includes a pure and traditional Tibetan diet of *rtsam pa*, yak and sheep meat.[21] In several of the present cases, the expression of the ideal of compassion went as far as giving free diagnosis and medicine to impoverished patients. Those lineage doctors who work privately outside of the main state health institutions, often chose to do so or had retired from their Mentsikhang work, in order to be able to provide free medical services.[22] In the past, it seems that doctors often treated patients without any explicit charge but did receive voluntary donations in the form of food products. However, there were and are large differences in financial means among student lineage doctors, depending upon their family background and social status. Medical teachers who did not belong to the

[20] If there were two brothers in a medical lineage, it was always the older one who would teach the younger. In the teaching lineage diagram (Figure 1) 'doctor' (*sman pa*) brothers are marked by a simple horizontal line in between while the transmission arrow is indicated from older to younger brother.

[21] Senior lineage doctors considered fish, eggs and pork as unsuitable foods. One doctor, while he was treating a patient in Beijing, made sure to take his own ration of *rtsam pa* with him so that it would last for several months. Some senior doctors pointed out that the newly introduced Chinese food among town-dwelling Tibetan nomads has caused many of the health problems. However, some of the younger doctors of Tibetan medicine were not so strict in their outlook and behaviour, and were smoking, for example.

[22] As a doctor employed in a state clinic there is no choice but to charge patients for medicine. However, there are problems with sufficient supply of Tibetan medicine in rural areas and clinics, since the government supplies and promotes the use of 'modern medicine' in such a way that Tibetan doctors who do not have the means and possibility to gather their own herbs in order to help patients have to administer Western medicine. This is of course quite dangerous, since only very few among them have had a proper training in Western medicine.

immediate family, and came from afar, were either invited by a student's family to stay with them for some time, receiving cattle and other items as payment for their teaching. A student could also live in a doctor's family for some time, often sharing lessons with a doctor's son of the same age. Outside of family medical lineages, sometimes a lama would recognise the potential of a novice to become a doctor, and thus the latter was advised to learn and practise together with a knowledgeable lineage doctor.

In general discussions about Tibetan medicine, lineage doctors openly stressed that there is no direct relation between religion and medicine. However, hints were sometimes dropped more discreetly: "In the past, the most famous doctors were both lama and physician. Nowadays, many physicians are like one-eyed doctors, since they do not believe in religion".[23] Also, senior lineage doctors would certainly stress their personal relationship with various Bon 'Tantric masters' (*rtogs ldan*), most of whom were locally famous among the Bon communities of Nagchu, and who had empowered them to perform Tantric ritual cycles by providing them with 'initiation' (*dbang*), 'authorisation' (*lung*), and 'explanation' (*khrid*).[24] Furthermore, most doctors whom I had interviewed agreed that not every illness which is diagnosed can be healed by medicine, and that some illnesses need to be treated by ritual specialists. And when I questioned a local lama, a 'Tantric practitioner' (*sngags pa*) and a former 'spirit medium' (*lha pa*), they all stressed their respective forms of specific ritual expertise, claiming that they had no medical knowledge at all and nothing in common with doctors, or with each other for that matter. One lama explained to me ironically, "Sick people go to the doctor, dying people call upon my services".[25]

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[23] Once I was told a story of how a lineage doctor did not recover from a nasty cough, in spite of administering several treatments. However, when he went on pilgrimage to Gangs Ti se, he drank two cups of water from the 'Tirtapuri' (i.e. Pre ta pu ri) hot springs and was cured from his condition in a short time.

[24] Next to the propitiation of important Bon tutelary deities, especially Dbal gsas rngam pa, Dbal chen ge khod and Stag lha me 'bar, the *sman bla* ritual of the Bon Medicine Buddha was generally considered as important among the senior doctors in order to purify oneself and to generally empower one's medical practice. One monk doctor also practised specific breathing and movement exercises (*rtsa rlung*) for mental and physical purification (on *rtsa rlung 'phrul 'khor* see Chaoul, this volume).

[25] In fact, he was difficult to meet at home since he was always away visiting bedridden patients.

However, when looking at possible motives for such dissociating assertions of boundary markers among doctors and specialists of ritual healing, one should consider socio-political and professional concerns. We know that in cases of certain types of illness, especially those believed to be caused by agents such as 'spirits' (*gdon*) and 'defilements' (*sgrib*), and instances of soul loss, patients will seek help from a variety of healers until they consider they are cured. In the past, these healing specialisations were certainly less well distinguished since they were not politicised or censored by being labelled 'false' or 'superstitious practices'.[26] On the other hand, lineage doctors surely seek legitimation in the sense of a professional distinction from other types of 'folk healers'. Thus, among the most prized possessions of these lineage doctors were medical texts, even handwritten versions of the memorised *Rgyud bzhi* (Plate 2),[27] inherited medical instruments such as the silver spoon used to measure powdered medicinal ingredients, copper needles for moxibustion or different knifes for blood letting (Plate 3). These embodiments of healing power among doctors are as much effective symbols of professional knowledge as a special statue or a 'healing stone' (*gter rdo*) is for a lama or a *lha pa*.

To summarise the above, and even though the question of how medical and religious knowledge and identity relate to each other cannot be answered in a satisfactory manner here, the primacy of medical knowledge over religious affiliation was clearly evident among the Bon lineage doctors I interviewed. On the one hand, several of their medical teachers belonged to Buddhist schools. On the other, the wider social network among Bon pos seems to have been, and to have remained, a strong link extending well beyond former tribal and contemporary county boundaries to regions as far away as Tsang (Gtsang), Amdo and Ngari (Mnga' ris), between which there were and are exchanges of teachers and students. While these long-distance connections are surely of great interest, and are partly related to the search for sponsorship

[26] Possibly, they were also less oppositional and more mixed—and very likely, on an unofficial level, many of them are still so in practice, and trusted healers of good reputation will recommend each other depending on what kind of illness has been diagnosed.

[27] This handwritten text was produced from memory by the lineage doctor Spyi 'dul (see below), shortly before the Cultural Revolution. It was written down according to the oral teachings based on the *Rgyud bzhi*, as they were transmitted to him by his teacher 'Brong tsha Dbal gsas skyabs. Spyi 'dul hid his books like a treasure in a buried box in 1966. Out of five such handwritten books only two survived.

and trade opportunities by some monks and monasteries, in the following section I will instead be exploring the complexity of the local networks of Bon lineage doctors in two rural counties of Nagchu Prefecture.

THE MEDICAL LANDSCAPE IN RURAL NAGCHU

Fernand Meyer (1981) reminds us that there was no such thing as a public health system in Tibet prior to the 1960s, and that only few doctors or other healing specialists were available outside of big monastic establishments or the medical institutions of Lhasa. However, in 1916 some modest efforts to build up public health facilities in Lhasa began with the establishment of the more secularised Lhasa Mentsikhang by the famous monk-doctor Mkhyen rab nor bu (1883–1962) and the 13th Dalai Lama (1876–1933). Lhasa now has a better public health system than any other region of the Tibetan Plateau. In contrast, the medical landscape in rural areas of Tibet was and still is very variable in terms of access to medical services. The practice of Tibetan medicine appears to depend in part upon local ecology, especially the availability of medicinal herbs, minerals and animal products in an area, and also upon the distribution of medical knowledge throughout specific communities, as well as local initiatives and resources to invite doctors from outside an area. We do not know much about the local history of Tibetan medical practice in areas such as Nagchu. The only way to find out is by way of oral history, by interviewing local doctors and families. Even a record of recent (post-1970s) changes in the local public health system remains to be written for the area of Nagchu.[28]

Concerning the local ecology of the Nagchu Prefecture, I was told that the counties of Nyi ma, Shan rtsa, Snyan rong and A mdo provide mostly minerals and wildlife products, whereas Sbra chen, 'Bri ru and Sog County would be rich in herbs. Special 'valley herbs' (*rong rtswa*)

[28] What I came across was a rather curious anecdotal story about a Chinese doctor who had treated nomads in Nagchu with 'Western medicine' (Chin. *xiyi*) at the end of the 1970s. His newly introduced stethoscope unintentionally became the object of blessing and veneration among his nomadic patients. They would request the doctor to press the stethoscope onto their heads in order to remove headaches, or onto their knees to remove arthritis. The doctor was ashamed about these 'treatments' but admitted to the possibility of having helped his patients by consoling them in their own way, and thus making them happy (Ma Lihua 1991: 187, 188).

grow in the lower areas of 'Bri ru. More precisely, Sbra chen seems well-endowed with about 350 different types of medicinal products, i.e. about 200 medical herbs, and other minerals and wildlife products. Nomad families collect 'Yartsa Gumbu' (*dbyar rtswa dgun 'bu*) here to earn cash, while privately practising lineage doctors use it to exchange for other medicinal ingredients that are not locally available.[29] In contrast, the areas of Rdza dmar and greater Snyan rong, located at a higher altitude than Sbra chen, are said to provide only sparse growth of both grass and medicinal herbs. Only around 50 to 60 different kinds of medicinal herbs grow in this area, of which about 30 are very common. Several privately practising lineage doctors there do produce their own medicines independently and in order to be able to treat poor patients for free. For many, they provide the only medical treatment possible since the TAR public health system has become unaffordable or is not accessible in the first place. With the help of colleagues and family, these doctors collect and then exchange their surplus of local herbs and minerals, for example, to the medical factory of the Nagchu Mentsikhang, in return for other non-local herbs which they require. If prices are too high there for specific and commonly used herbal ingredients, such as for *a ru*, *ba ru* and *skyu ru* which grow in Nepal or India, doctors try to obtain them through direct trade at the Nepalese border.[30] Nevertheless, the free treatment of patients entails a heavy economic strain upon these doctors and their families.

Generally speaking, because of Nagchu's rather barren, high altitude landscape between 4500m and 5000m, minerals seem to play an important role as local ingredients in medicinal compounds. The Chinese woman writer Ma Lihua, who travelled through Nagchu during the late 1970s and early 1980s, confirms:

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[29] Several articles have recently appeared concerning the importance of *Cordyceps sinensis* as a medicinal trade product. The Tibetan name can be translated as 'summer grass - winter worm', indicating its extraordinary metamorphosis from a 'worm' (actually a moth larva) into a type of 'grass' (i.e. fungus) which is used especially in Chinese medicine, but much less so in Tibetan medicine. It has become a very important 'cash crop' for many Tibetan nomads (see Boesi 2003 and Winkler 2005).

[30] Trade in medicinal herbs between distant areas seems to have been lucrative and important even in the past. George Roerich, for example, mentions "Chinese- and Japanese-made medicines" being traded in the Nagchu area by merchants from Lhasa and Si ling (Xining) in the 1920s (Roerich 1931: 339).

> Of all Tibetan medicines, those made of minerals are considered most efficacious and maintained particularly by the northern school because there is scarcity of plants here, particularly for medicinal use; on the other hand, minerals for prescriptive purposes are plentiful.[31]

However, as I will show in the following sections, it is the quality of medical education through lineage that might play the most decisive role for the quality of medical treatment in rural Nagchu today.

Today, many privately practising doctors carefully collect and produce their own medicines. Neither they nor their patients can afford or would want to buy medicine—whether Tibetan or 'Chinese' (i.e. biomedical products)—from one of the *xiang* or *xian* clinics. However, since the founding of the Nagchu medical factory, its products were held in high esteem locally, especially when compared with those from the Lhasa Mentsikhang factory, which has a rather dubious reputation. It was explained to me that the Nagchu factory adheres strictly to traditional recipes and does not use substitutes in its medical compounds; at least this was the case while a trusted local doctor used to be its director.[32] However, he passed away prematurely in 2001, and is still mourned by his colleagues. He was a highly respected person and a part of the relatively close network of lineage doctors from Rdza dmar.[33]

When talking about the variety in quality and availability of medical care in rural Nagchu, one has to take into account the socio-political and historical contexts as well as ecological and economic considerations. This issue will be explored below by way of a selection of biographical interviews with doctors and ritual healers from Snyan rong and

[31] Ma Lihua 1991: 182. What she means by the 'northern school' of Tibetan medicine remains unclear. She claims that the 'northern school' specialises in the treatment of 'cold diseases' whereas the southern does so for febrile diseases. Also, the northern school seems to be more inclined towards Bon (Ma Lihua 1991: 179). Since I have not encountered such a claim at all during my fieldwork in Nagchu, I would like to leave this question open until further clarifications have been undertaken. For a discussion of the 'Northern School' (*Byang lugs*) in the Tibetan tradition, see Hofer (this volume).

[32] I have no way to verify this claim. Further research into the domain of the acquisition of, and trade in, herbs and the production process of Tibetan medicine at the Nagchu medical factory needs to be undertaken.

[33] See the diagram (Figure 1) to locate the former director of Nagchu Mentsikhang, Kun 'dul, older brother of Seng ge, and their links with the professional and kinship network among lineage doctors in Rdza dmar. This diagram is not exhaustive but is primarily oriented towards showing the historical connections among local lineage doctors in this area. Spellings of names can also vary (as by informant or cf. Byams pa 'phrin las 2000), for example Rma rong Khro gsas or Dmar rong Khro gsas, Yog ru Lha rje or Yob ru Lha rje, A rgya or A brgya.

Sbra chen counties in order to build up a certain understanding of the situation.[34] At the same time, it should be noted that these senior lineage doctors represent a kind of local elite due to their lineage status. Their status can be compared with other younger, upcoming doctors without lineage background, who are less well-educated and who might not be able to practise in their own communities, but only as 'outsiders' in other remote places.[35]

Historically speaking, the area north of Nagchu County was populated by nomadic tribes who belonged to the Thirty-nine Tribes of Hor (Tsho ba so dgu).[36] Noteworthy for the purpose of this article, are the Rdza dmar tribe whose territory now comprises the southern part of contemporary Snyan rong County, and the Hor Ye tha tribe from Sbra chen County. These former tribal areas were the locations of my fieldwork during autumn of 2003. The Hor pa maintained few monasteries, most of them belonging to the Bon religion.[37] Unlike some of their Buddhist counterparts, Bon monasteries never developed monastic

[34] The following explanations are in no way exhaustive and focus on the oral history of medical lineages. Other important aspects for understanding the variety of medical traditions, such as the way in which medical policies are implemented locally, are not discussed in this chapter but should be explored further.

[35] I thank David Holler (in personal communication) for pointing out the various and economically quite difficult situations for young doctors in other nomadic areas of Nagchu Prefecture, such as in Dam shung.

[36] Phuntso Tsering Sharyul gives a short historical sketch of the famous Thirty-nine Tribes of Hor (2003: 71). See Roerich for a more general description on the "The Horpas and their Country" (1931: 333ff, chapt. XVI). See Map for an outline of the former tribal area of Hor. For statistical and climatic information collected on present-day Nagchu, see Studer 2002 and Baimatsho 2003.

[37] See Dondrup Lhagyal (2000: 460) and the monastic history of Nagchu (Nag chu sa gnas srid gros lo rgyus rig gnas dpyad yig khang). It is evident that the counties of Sbra chen, Snyan rong and 'Bri ru possess the highest concentration of Bon monasteries in the Hor region. Sog County, however, is almost entirely Buddhist and maintains quite a large and renown Tibetan hospital. Roerich writes, "Bön is prominent in the region of western Hor and holds undisputed sway over all the Hor tribes" (1931: 353). Bon po communities here had strong contact with the main central Tibetan monastic centres of Bon religion, Sman ri and G.yung drung gling, whose lamas and monks regularly came to visit Nagchu to give teachings, and also to collect donations, upon which they depended heavily. As will be shown later, several lamas from G.yung drung gling taught medicine to Bon lineage doctors in the Nagchu area. Also, at the instigation of important abbots and lamas from Sman ri monastery, the monastery of Sha ru was founded in Rdza dmar at the end of the 19th century (Phuntso Tsering Sharyul 2003: 81). Roerich discovered two complete sets of a Bon *Bka' 'gyur* and *Bstan 'gyur* in this monastery in 1928 (Roerich 1931: 357); see also his description of the monastery (1931: 361ff). He also mentions, with specific iconographic details, the Bon Medicine Buddha (Sangs rgyas sman bla) depicted on a wall painting at the site (1931: 363).

medical schools. Instead, medical knowledge was mainly transmitted by family or teacher-student lineages. But, in addition to this, there were also certain famous religious practitioners, such as *rtogs ldan* and lama, who gave teachings on medicine, healing rituals and astrology (*rtsis*), as well as initiations and blessings, to lineage doctors. In the following, I will give a good example of this from Sbra chen County.

MEDICAL KNOWLEDGE IN SBRA CHEN COUNTY

In the recent history of Sbra chen County, are three Bon *rtogs ldan* practitioners who were especially famous for their medical and astrological knowledge. These are Be ru skal bzang (or mkhas dbang?), Rag shi (or shu?) rtogs ldan Dri med g.yung drung (d. 2001) and Kha bo rtogs ldan Shes rab phun tshogs (d. ca. 1998). In addition to these three, the name of Kun bzang lhun sgrub, the nephew of Rag shi rtogs ldan, is also well-known. Kha bo rtogs ldan, for example, was especially famous for *rtsis*, and so he produced the astrological calendar for the Sbra chen Mentsikhang for several years, beginning in 1984. Yet, following his death, no one else was able to continue his craft.[38] Generally speaking, senior lineage doctors regret the dramatic decline of the importance of astrology for medical practice at all levels, and in all modes of learning in Tibetan medicine. This development is also considered dangerous by some, since it is thought to render medical practice less precise and thus less efficacious.[39] Rag shi rtogs ldan, in turn, is known to have given initiations, transmissions and empowerments (*dbang, lung, khrid*) to many people, among them several doctors whom I had interviewed. The local doctors' awareness of the need for preserving the memory and knowledge of such recent medical lamas is

[38] Even today, informants told me that it is especially the older generation of Tibetans who ask for almanacs calculated by knowledgable *rtsis pa* at the Mentsikhang.

[39] At the moment, I can only guess what the reasons for this decline might be. Astrology is an important part of Tibetan culture in general, not just of Tibetan medicine. However, astrology belongs to that part of Tibetan culture which falls somewhat into the politically censored realm of 'superstition' in Chinese state cultural policy, and under which various forms of Tibetan divination, for example, are now completely outlawed. Furthermore, it might not be 'scientific' enough and thus might have fallen under the hammer of biomedically stipulated sanctions concerning training in Tibetan medicine in many contexts. Similarly, the use of the *I Qing* has declined in Traditional Chinese Medicine (TCM).

high. For example, a lineage doctor from Sbra chen Mentsikhang now tries to collect the biographies of the three *rtogs ldan* in order to publish them.

Next to *rtogs ldan*, several lamas also became well-known in the area for their healing skills. Despite the fact that there is no tradition of Bon monastic medical schools, certain monasteries seem to have attracted lamas with medical knowledge. One such example is G.yung drung rab brtan gling or Spa tshang dgon, formerly the largest monastery in the Hor area, which was founded by a Spa lineage descendant, Spa ston Nam mkha' bzang po, in 1847.[40] Several decades later Spa ston Nyi ma 'bum gsal (b. 1854) turned it into a flourishing establishment with about four hundred monks, and both a dialectic college (*bshad grwa*) and a Tantric college (*sgrub grwa*). He also composed religious and medical works, and became the 'root lama' of the famous Bon scholar Ga rgya Khyung sprul 'Jigs med nam mkha'i rdo rje (1897–1955). Khyung sprul's family, the Ga rgya, were well-established in Sbra chen because his father was the *Hor Blon*, or Minister of the Hor King. Ga rgya Khyung sprul, as he is commonly called in Nagchu, also composed four important treatises on Tibetan medicine based upon Bon *gter ma* texts.[41] Later in his life, he settled in Ngari and established the Bon monastery of Gur gyam there, near the famous holy mountain of Gangs Ti se, better known outside of Tibet as Mount Kailash. Nevertheless, until recently, Spa tshang monastery has continued to produce monks and lamas knowledgeable in medicine.[42]

Ga rgya Khyung sprul's main student and successor, Bstan 'dzin dbang grags (b. 1922), a native of Hor Ye tha (Sbra chen County), is possibly the most famous and nationally recognised Bon doctor in contemporary Tibet. Bstan 'dzin dbang grags ('Dainzin Wangzha' in the Chinese rendering of his name) has established several medical facili-

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[40] See Dondrup Lhagyal on 'The Spa family in the Hor area' (2000: 460). The Spa lineage is one of the five major Bon religious lineages who maintained their own monasteries. On the history of Spa tshang dgon, see *Nag chu sa gnas srid gros lo rgyus rig gnas dpyad yig khang*, 325–33.

[41] For this text see bibliography. See his biography in Dpal ldan tshul khrims 1972 and Kværne 1998.

[42] For example, the now retired doctor from Sbra chen Mentsikhang, 'Bru zhig Khri shes nyi ma, was taught by Dar ma rgyal mtshan from Spa tshang dgon, whose teacher was the famous doctor and lineage lama 'Brug rin po che (Spa ston G yung drung bstan pa 'brug grags) from the same monastery. For more details on this particular monastery, see Phuntso Tsering Sharyul (2003: 131–36).

ties in Ngari, among them a medical school open to all kinds of students which he founded in 1984 near Mount Kailash.[43] This example hints at how medical knowledge can also be transmitted through a religious teacher-student lineage transcending locality/regionality, and thereby transferring knowledge to other regions through the movement of persons and texts. Here again, it is the personal relationship between teacher and student that is most decisive—in contrast to other notions of lineage discussed above.

The fact that text and locality are also indicative agents in the transmission of Tibetan medicine, is revealed in a local narrative among Bon doctors from Sbra chen, about how Ga rgya Khyung sprul's treatise on medicine found its way 'home' again. A pilgrim from Nagchu with the name Rba bo rdo rkyang had travelled to Mount Kailash, and there had been given Ga rgya Khyung sprul's text in order to take it back home to Nagchu, so that it could benefit the doctors and patients there. Rag shi rtogs ldan from Sbra chen then obtained the work, learnt the medicinal recipes contained in the text and passed these onto his nephew, Rag shi Kun bzang lhun grub, who in turn apparently passed this knowledge down to his nephew Rin chen blo gros (born in 1951). The latter is now practicing as a lineage doctor in Nagchu township, using these recipes for his medical practice and teaching.[44] It is interesting to note that Ga rgya Khyung sprul's treatise on medicine seems to be better known today among Bon doctors coming from his home area of Sbra chen County (and more often used in their medical practice as well), than among lineage doctors from Rdza dmar (Snyan rong County). This fact, too, indicates that something like a regionally based knowledge continues to be perpetuated through certain medical lineages, texts and oral historical narratives.

When I asked the lineage doctor Be ru Khri med, the leader of the Sbra chen Mentsikhang department, whether there were many doctors practising here in the past, he replied, "No, not so many but some famous ones" (i.e., such as those mentioned above). Today, he adds,

[43] He has served as a teacher to many students of Tibetan medicine. For information about him, his medical school, and the monastery of Gur gyam, see Byams pa 'phrin las (2000: 554–56); *Stod mnga' ris skor gsum gyi lo rgyus* (1996: 297–336); and http://www.tibetinfor.com.cn/english/culture/medicine/hospital/ ho_02.htm.

[44] Rin chen blo gros had moved from Sbra chen to Nagchu town and organised a small private medical training programme supported by the Trace Foundation.

there are considerably more Tibetan doctors around, including some in Sbra chen, whom he has specially trained himself.[45] In addition to Be ru Khri med, there seems to be only one other lineage doctor still practicing Tibetan medicine in Sbra chen. His family name is Sngags pa tshang, belonging to the lineage (*rus pa*) of Khyung po, and he continues the medical tradition of his family in the 7th generation. As a kind of proof of his family heritage, he displayed to me a special metal object used for grinding and compounding medicine (*sman sdud snod*).[46] Furthermore, he had inherited a medical text that was considered 'local' in the sense that it was a personally made copy or an original book from his great-grandfather.[47]

RDZA DMAR DOCTORS FROM SNYAN RONG[48]

The two most well-known senior doctors of Tibetan medicine who practice in the Nagchu Mentsikhang, both of whom happen to be Bon doctors with a strong lineage background, are A rgya (b. 1943) and Spyi 'dul[49] (b. 1935). Their homeland is very nearby in the Rdza dmar area of Snyan rong County. They began to work at the prefectural Nagchu Mentsikhang (Nag chu sa khul sman rtsis khang) in 1984.[50] It became

[45] In 1998, together with his senior colleague 'Bru zhig Khri shes nyi ma, he established a small Tibetan medical school with about 30 students from the local area. The course was initially supported by the government and ran for four years. The students completed the course successfully. However, because of scarce funding resources, these doctors were not able to repeat such a course.

[46] It was made of extremely heavy iron covered by a cushion-like leather surface. It was not entirely clear—also not to Sngags pa a sbo himself—how this tool was used since it did not look as if it could contain anything. Rather, it looked like the foot upon which a vessel, for example for grinding medicine, could be placed.

[47] The text is entitled: *Gso rigs kyi man ngag sman nus kyis dngos 'dzin kun gsal nyi ma'i dbang po*. n.d., n.p. It lists local names of medical compounds, I was told. However, the two lineage doctors present were discussing the probability of it being a local text, i.e. referring to locally available medicinal herbs and their local names, or being a (possibly locally adapted) copy of the now generally available *Shel gong shel phreng*, written in 1727 by De'u dmar Bstan 'dzin phun tshogs. They did not, however, exclude the possibility of this local text being the original version of the *Shel gong shel phreng*.

[48] The network of teacher-student lineages, including some of the family ties among lineage doctors in Rdza dmar (Snyan rong) is outlined in Figure 1.

[49] His full name and title is Sman rab 'byams pa Rkang thung Spyi 'dul.

[50] When the Mentsikhang was established, there were about twenty Tibetan medical professionals, but only few of them were trained thoroughly in Tibetan medicine. However, there was a collegial spirit among the different types of doctors, and teachers

evident that they are representatives of the 'old school', i.e. local doctors of integrity who truly adhere to their traditional learning and lifestyle, and who shared several teachers in common. Of course, they are not the only senior lineage doctors around, and they have also had to adapt to the Mentsikhang system, thus prescribing mass-produced medicine instead of privately collecting and personally producing it themselves. However, their acquisition of medical knowledge will serve as a local case study for certain characteristics of the lineage model of transmission.

Spyi 'dul, for example, emphasised the important role of astrology (*rtsis*) in Tibetan medicine, since this is generally a complementary aspect of the Tibetan medical system, although its practice has steadily declined since the 1960s. Astrology is—next to the treatment of women's diseases—also one of the skills that Spyi 'dul is well-known for.[51] He had learnt astrology from his father Rkang thung Tshe sgrub, who was a secretary of the Rdza dmar tribe, and who possessed a theoretical knowledge of medicine and a practical one in geomancy (*sa dpyad*). Even though Spyi 'dul's task as a young man was to take care of the family's salt trading business, he found time to study medicine as well. Among his teachers were his maternal uncle Rda ru Gsas 'bum who taught him divination (*mo*) and poetry (*snyan ngag*). At the same time, Rda ru Gsas 'bum's father, Rda ru Lha dbon, (i.e. Spyi 'dul's maternal grandfather), was a famous doctor (*lha rje*) and taught Spyi 'dul the *Rgyud bzhi*, while he learnt *gtar* (blood letting), and *me btsa'* (moxibustion) from his cousin, that is, his father's sister's second son, Yog ru Lha rje. Both Yog ru Lha rje and Spyi 'dul himself had been students of the most famous lineage doctor of Rdza dmar area, 'Brong tsha Dbal gsas skyabs (more about him below), a contemporary of the great Mkhyen rab nor bu (1883–1962).[52] Yog ru Lha rje was also the father

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like Shes rab mchog ldan from G.yung drung gling monastery were invited to teach not only medicine but poetry and drawing as well. Spyi 'dul himself also taught several of the inexperienced doctors in special training courses. Presently, there are only two doctors from Nagchu practising at the Nagchu Mentsikhang, A rgya and Spyi 'dul, whereas all the others come from Lhasa and belong to the new generation of institutionally trained doctors.

[51] For a portrait of Spyi 'dul see Plate 4, and for his short biography, see Byams pa 'phrin las 2000: 593–95.

[52] 'Brong tsha Dbal gsas was also related to Spyi 'dul, being his mother's father's sister's son.

and teacher of the Rdza dmar lineage doctors Seng ge and Kun 'dul.[53] Furthermore, medical and herbal knowledge was taught to Spyi 'dul by the Rma rong family, a Buddhist medical lineage in which the eldest brother Rma rong (A rdo) Khro gsas was the main agent. Rma rong Khro gsas (1899–1999), as well as his brother A thob, presumably about 100 years old and still living in 2003, also taught medicinal plant knowledge to other lineage doctors in Rdza dmar, among them A rgya and Seng ge.

Spyi 'dul told the following story in order to illustrate how life-saving astrological calculations were considered to be for Tibetans prior to the 1960s. Around the 1920s and later, the Rdza dmar tribe flourished greatly. They were quite prosperous because of successful raids, but they also had some quite famous doctors, astrologers and intellectual people among their ranks. One such person was Dge slong bzod pa, who was famous for his prophecies made on the basis of *rtsis*. He foretold a big snowstorm for the year of the Iron Hare (1951). In the previous year, the government of Lhasa (Dga' ldan pho brang) had increased its taxation on the Hor tribes by one yak skin per household. Dge slong bzod pa foretold that even though in that year it would be difficult to meet the tax obligation, the following year, yak skins would be abundant. And indeed, about 100,000 yaks died in the snowstorm in the following year.

In the mid 20th century, one of the most celebrated Bon lineage doctors from Snyan rong was 'Brong tsha Dbal gsas skyabs (or Dbal gsas for short). He came from an impressive family lineage of ten generations of doctors, whose members were named for me by A rgya, one of his former students (see Figure 1). He taught the *Rgyud bzhi* in theory and practice, but also passed on his herbal knowledge, as well as the surgical treatment of *thur ma* that has ceased to be practised since the 1960s.[54] Dbal gsas's main lineage teacher was his grandfather 'Brong

[53] See diagram (Figure 1) where Spyi 'dul's father, his maternal uncle and grandfather are placed vertically above him, as part of his *pha spun*. Yog ru Lha rje must have been considerably older than Spyi 'dul himself, and shared a wife together with his older brother, Yog ru Dbang 'dul, with whom he fell out quite badly. Quite unusually, Yog ru Lha rje, being the younger brother, turned out to be the main medical teacher for his next of kin, including for both of his (or their?) sons, Seng ge and Kun 'dul.

[54] According to Spyi 'dul, this treatment is described in the *Rgyud bzhi* as being very painful and dangerous, but also powerful. It entails a surgical operation performed with a metal stiletto in order to let off 'steam' or 'vapour' (*rlangs*) from organs such as the lungs, the heart and the stomach, as indicated in the *Final Tantra* (*Phyi ma rgyud*) (Olaf Czaja, personal communication). The instrument can be shaped like a long spike

tsha Jos skyabs. Among the line of teachers in his wider lineage tree, there was also a famous Bon po *gter ston* from Kham with medical knowledge, Kun grol grags pa 'Ja' tshon snying po (b. 1700).[55] Another one of these lineage teachers was a lama from G.yung drung gling monastery, Mkhas sgrub lung rtogs rgya mtsho, who also composed a Bon history during the 18th century.[56] Dbal gsas also went to study at the monastic medical school of Chagpori in Lhasa, in order to complete his knowledge. His former student Spyi 'dul recalls:

> At that time in Lhasa one noble lady fell ill, having problems with her lungs, and even the famous Mkhyen rab nor bu from Chagpori was not able to cure her. Dbal gsas, however, had the knowledge of doing minor surgery, so he was able to treat her successfully through *thur ma.*

Dbal gsas received rewards and gifts for his successful treatment. However, medical students in Lhasa today believe that *thur ma*—used for surgery of organs other than the eyes—has not been practised anywhere in Tibet for three hundred years or more. In explanation for this, a story concerning a dangerous failure of this type of treatment is circulated at the Lhasa Tibetan Medical College, according to which the Regent Desi Sangye Gyatsho (1653–1705) had incidentally injured the Fifth Dalai Lama's heart while treating him with *thur ma* for a lung problem. A ban of *thur ma* had apparently been imposed since that time.[57] Yet, the fact that an 'outsider' like 'Brong tsha Dbal gsas from rural Nagchu still knew how to use a method that apparently had already ceased to be applied for several hundred years in Lhasa itself, gives us information about, and proof for, a Lhasa-centric politics and discourse of Tibetan medicine, and one which is historically characteristic of other areas of interest to the Dga' ldan pho brang state. Despite tremendous socio-political changes, it is obvious that certain social

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with different metal points or formed like a hollow pipe, and is either heated up or used 'cold'. There were different lengths and sizes of instruments for various functions. More commonly, *thur ma* has been used for eye surgery.

[55] Because of their dates, these figures are either to be understood in a wider historical sense as having been teachers in the lineage of Dbal gsas, or my informant might have intended to refer to their later reincarnations who taught Dbal gsas directly. Thus, according to Dan Martin, the 6th reincarnation of Kun grol grags pa 'Ja' tshon snying po, known as Kun grol hum chen 'Gro 'dul gling pa (1901–1956), could have possibly been a personal teacher of Dbal gsas (Martin, personal communication).

[56] See Martin (1997: 175, no. 429).

[57] I thank Mingkyi Tsomo, former student at the Lhasa Tibetan Medical College, for this information.

hierarchies and the myths connected to them have remained and been locally perpetuated and transmitted until today. Certainly, this story proves that among Lhasa's medical institutions and rural lineage doctors, different medical treatments and expertise existed.

Furthermore, Dbal gsas was not the only doctor in Snyan rong who still knew how to practice *thur ma* during the mid-20th century. Another renowned doctor and teacher, Chos dbyings rdo rje (1905–1977), who originally came from Amdo, also taught *thur ma*, as well as the techniques of *myig phye ba* or 'open eye surgery' and also the *dug bcos* treatment against poisoning. Chos dbyings rdo rje was a former monk of 'Bras spung monastery, and later became a very famous doctor in Nagchu. He married into a family from Sog[58] where he settled and treated patients. However, he seems to have remained notoriously poor, possibly also because he treated his patients for free. Chos dbyings rdo rje himself had several teachers, one of whom was Kong sprul Blo gros mtha' yas (1813–1899), the famous Ris med savant from Khams. Later he trained—like Dbal gsas—for three years with Mkhyen rab nor bu at Chagpori in Lhasa. In Nagchu, he successfully treated Tibetan governement troops who had terrible problems with venereal diseases while serving under the Lhasa-appointed Governor of the North (Byang spyi) Pha lha Thub bstan 'od ldan (b. 1911).[59] Hence, the people called Chos dbyings rdo rje the 'doctor of Chinese diseases' (*rgya nad sman pa*), since *rgya nad* referred to venereal diseases.

One of Chos dbyings rdo rje's students, A rgya from Rdza dmar, who is Spyi 'dul's colleague at the Nagchu Mentsikhang, in turn became renowned for being able to cure poisoning—a treatment that his teacher was already famous for—when he was able to heal two

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[58] I guess that he must have settled in Sog County, which in contrast to Snyan rong and Sbra chen is a predominantly 'Buddhist' county. Today, there exists a rather well known and established Mentsikhang in the town of Sog County, which has its own buildings and staff, and is separate from the Peoples' Hospital. The Trace Foundation supports a project on the cultivation of medicinal herbs there.

[59] The Byang spyi governors were sent to establish central government authority over the Hor states and neighbouring Byang thang pastoral communities in the early 20th century, which amounted to little more than enforced tax collections for much of the time, something highly resented by the Hor communities. Pha lha thub bstan 'od ldan was appointed Byang spyi in August 1942, and served until about 1947. He is still notorious in parts of Hor for the killing by deception of Dkon mchog rgyal mtshan, alias Ga rgya 'Gram nag (1908–1944), the brother of the Bon lama Ga rgya Khyung sprul 'Jigs med nam kha'i rdo rje whose medical texts are used by the lineage doctors of Hor. I thank Toni Huber, who is working on the life-story of Ga rgya 'gram nag, for this information.

patients from 'Bri ru county who had been travelling in Kong po, a region notorious for cases of poisoning.[60] A rgya thus became well-known for curing cases of 'poisoning caused by man-made compounded poison' (*sbyar dug*), one of three different types of poison including 'natural poison' (*dngos dug*)—being either 'immobile' in plants (*mi rgyu ba'i dug*) or 'mobile' in some animals (*rgyu ba'i dug*)—and 'poison caused by way of food poisoning' (*gyur dug*). Even though A rgya had initially learnt medicine from his maternal uncle Bsod nams grags pa, as well as from another 'uncle' of his who was a renowned lama and teacher of Tibetan medicine from the Bon monastery of G.yung drung gling, Shes rab mchog ldan (1933–1996),[61] he considers the famous lineage doctor Dbal gsas as his main medical teacher. He clearly identifies with the latter's knowledge and prestige, which he continues to pass on to quite a considerable amount of students of his own. Even though he is not personally related to Dbal gsas, he feels responsible for, and identifies with, his family lineage transmission, possibly also since Dbal gsas's own son Bsod nams bkra shis had passed away so early, and because Dbal gsas's great-grandson, who was instructed by A rgya in Tibetan medicine, does not seem interested in continuing this famous medical lineage.[62]

Successful treatments in difficult cases of illness, and among patients with high social status (in former times nobles, in present times government and military officials), often form an important part of a doctor's narratives and self-image when asked about their specific abilities of healing.[63] For a contemporary example, in the years 2000 and

[60] For A rgya, see Plate 5. On Kong po and its poisoners, see Karmay 1998b.

[61] A rgya referred to Shes rab mchog ldan with the term *a zhang* ('maternal uncle'), however, he was not sure about the actual family ties that exist between them. *A zhang* can also be used, for example, for 'nephew'. See diagram, Figure 1.

[62] See diagram for A bu (Blo sgrub gyur med), born 1982 (Figure 1). A rgya certainly did not bask in reflected glory, however. It was clear that both he and Spyi 'dul very much regretted that the lineage of 'Brong tsha Dbal gsas skyabs was under threat. A rgya also did not call himself a lineage doctor (in the stricter sense) because he did not really come from a medical family lineage (except for his two monk doctor teachers whom he calls 'uncles'). However, since he clearly identified his medical knowledge and practice with Dbal gsas, and continues to pass on his knowledge onto Dbal gsas' great-grandson A bu, I argue that it is justified to call this a *sman pa rgyud pa* in the sense of a master-disciple apprenticeship.

[63] There are some remarkable parallels between senior Tibetan lineage doctors and 'senior Chinese doctors' (Chin. *laozhongyi*) concerning the "personal transmission of knowledge" (Hsu 1999: 88f). However, the stress on lineage membership seems stronger and more pronounced among Tibetan lineage doctors.

2001, A rgya was invited to go to Beijing three times each year for a series of one month stays in order to treat a high ranking Chinese military official in a military hospital there. At that time he was able to cure kidney, heart and liver conditions for this patient by compounding his own medicine, of which the raw materials were ordered from the Nagchu Mentsikhang pharmaceutical factory. A rgya received an official recognition for his treatment after this success.[64] One can easily understand why such narratives of successful medical treatments in hopeless or difficult cases are so crucially important for these doctors. They not only improve and legitimise a doctor's prestige among the people once the word gets around, but in the recent past such a reputation was even able to rescue a doctor's life and professional career during the persecution and imprisonments of the Cultural Revolution.

Today, it seems quite obvious that lineage doctors from rural areas outside Lhasa have retained certain traditional medical treatments, among them especially external treatments, as well as the use of cleansing medicines such as *bshal* ('purgatives'). Whereas the latter is not practised anymore at the Lhasa Mentsikhang, some of the other external treatments are still used in at least one small department (*dpyad bcos khang*) there.[65]

The example of *thur ma*, and the fact that its decline as a treatment follows a separate trajectory in terms of time and place, suggests that different historical developments in Lhasa, when compared to other areas of the Tibetan plateau, must have had a strong impact on the overall development of medical practice within the area of influence of the pre-modern Tibetan polity. As the example of the use of the *thur ma* treatment by 'Brong tsha Dbal gsas in Lhasa in the mid-20th century has shown, one could conclude that the process of standardising Tibetan medicine in Lhasa itself must have already been set into motion well before that, probably marginalising what were considered, for one reason or another, as 'dangerous treatments'. Apart from a narrative that appears more mythical than historical, however, we do not really know why this was the case. Additionally, there is clear evidence that in the 1960s and 1970s, certain medical practices were branded by state poli-

[64] Since he does not know Chinese, he had to take a student along to translate Chinese into Tibetan and *vice versa*.

[65] Again, I am indebted to Mingkyi Tsomo for this information. I do not know, however, why *bshal* is not practised at the Mentsikhang anymore.

cies as 'superstitions', later becoming marginalised practices like some of the external treatments mentioned above. It is also apparent that what are today rather neglected or 'marginal' forms of treatment among Tibetan doctors in Lhasa—and of course *thur ma*, which has totally ceased to be practised today, most likely because of the advancement of biomedical surgery—seem to have become the very treatments that rural lineage doctors are famous for using.

OUTLOOK

Senior lineage doctors in present-day Nagchu consider there has been a decline in comprehensive knowledge and practice of Tibetan medicine due to a more superficial and standardised form of teaching and learning within centralised, state medical institutions. This trend is generally understood as a severe loss and a threat to the complexity and efficaciousness of Tibetan medicine, turning it into something 'more basic' and 'less effective'. Also, privately practising doctors who produce their own medicine are among the few who are able to fill the gap in public health by providing medical treatment for free to the poor, who otherwise have no means for being cured. This was given as the main reason for private doctors to bypass state medical policies in various ways. On the other hand, those among them who have no knowledge of Chinese language, or of Chinese biomedicine, are increasingly confronted with patients who may take both types of medicine. Thus, they have no experience in the way biomedicine works or reacts with Tibetan drugs when taken together or one after the other. This dilemma might increase in places where Tibetan medicine is not available at all, and where the state keeps supplying subsidised biomedicine instead (often of poor quality, and if at all). In some places, for example, Tibetan doctors might diagnose the disease of a patient by taking the pulse while having to prescribe Chinese biomedical drugs. In a Mentsikhang setting, it might be the other way round, that is, modern diagnostic methods based on a modern anatomy and (probably) a hybrid of disease aetiologies, might be employed and finally Tibetan medicine is given as the treatment. Concerning the combined practice of Tibetan medicine and biomedicine, most of the senior lineage doctors considered this to be unproblematic and instead complementary, saying that 'old' diseases, i.e. chronic ones, are better treated with

Tibetan medicine which works slowly but in a sustained way, while 'new diseases', such as dangerous infections or appendix inflammations, are better treated by the fast effects of biomedicine or surgery. This opinion coincides pretty much with that of Mentsikhang doctors from Lhasa and even with that of doctors from the Dharamsala Men-Tsee-Khang. Only one or two senior lineage doctors were more careful and concerned about the unknown effects of simultaneous usage of both types of medical systems.

Tibetan medicine is an important part of Tibetan socio-cultural values and practice and one could argue that where those are strong, Tibetan medicine is supported and cared for among many rural Tibetan communities. Thus, I conclude that social embeddedness and transmission through lineage—whether by family or teacher-student relationship—empowers and legitimises both Tibetan doctors and different types of Tibetan healers whose cultural integrity, ethical behaviour and local knowledge in turn also empower their communities. As highly respected community members, they are concerned with passing on their knowledge of local medicinal plants and practices to the next generation. New study groups that have been formed with locally chosen students ensure the transmission of their medical knowledge—a hopeful sign that reveals a certain local flexibility within the overall public health system. Such medical subcultures have been supported either through private donations, by funding from a prefectural or county health bureau, or by international NGOs. Each of these different sources of support imply different limitations or opportunities in terms of the structure of training, and avenues toward clinical practice and income-generation for newly trained doctors. This new mode of transmission of medical knowledge, and its impacts within or outside of the public health system, requires further research and is beyond the scope of this article. Only further research will reveal whether or not the recent study groups initiated by knowledgeable and experienced lineage doctors can create an alternative and successful model of transmission of local medical knowledge and practice in the context of public health in the TAR.

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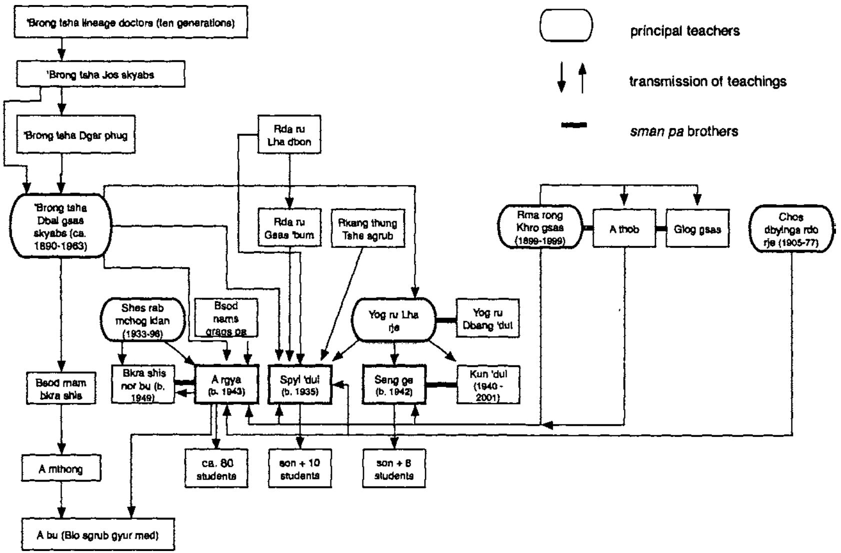

Figure 1. Teaching lineages among Bon doctors from Rdza dmar. Note that the vertical order roughly indicates patrilineal descent including uncles, nephews, and son-in-laws, while the horizontal levels signify members of the same generation.

Plate 2: Manuscript of the *Rgyud bzhi* handwritten from memory by Spyi 'dul

Plate 3: Medicine bags, silver spoon and copper needle

Plate 4: Spyi 'dul

Plate 5: A brgya taking pulse

A CRISIS OF CONFIDENCE: A COMPARISON BETWEEN SHIFTS IN TIBETAN MEDICAL EDUCATION IN NEPAL AND TIBET[1]

SIENNA CRAIG

When my father taught my brother and me, we learned at home, not in a school. We learned what medicine is by coming to know the plants in our area, cleaning and drying and grinding these plants into powders. We studied and memorised *dpe cha*, but did not know this thing called 'textbook'. Someday we hope to have a program like those in Lhasa or Dharamsala here in Nepal. This is still a dream. But when we think about such goals, or even the future of our small schools, it is important to think about curriculum. This concept is new for most of us.
—*Chairman of the Himalayan Amchi Association, Kathmandu, and Co-Founder of the Lo Kunphen School and Mentsikhang, Mustang, Nepal*

In most colleges, students don't get much clinical experience—at least not enough to be considered a skilled doctor. Some get this after, in a variety of clinical settings, but many more get channelled into other tracks, like marketing or producing medicines. But those who produce medicines also might not have more than a basic sense of the plants and other ingredients, or at least not much experience collecting. They don't learn these skills in detail anymore. They become more like pharmacists and marketing specialists, rather than healers. The same is true for teaching. You go through training only to arrive at the other side to be weighed down with teaching responsibilities and not a lot of time to test your own practice.
—*Professor, Tibetan Medical College, Lhasa, TAR*

INTRODUCTION

The forms and content of *gso ba rig pa* education bear directly on the health and well being of culturally Tibetan communities throughout the

[1] This paper is based on ethnographic fieldwork I have been conducting in Nepal since 1995, and the TAR since 2002. I would like to thank the Social Science Research Council, the Wenner-Gren Foundation for Anthropological Research, the National Science Foundation and the Department of Anthropology at Cornell University for their support of this work.

Himalaya and Tibetan Plateau now and in the future. Indeed, how one comes to know the mind and body, and to alleviate suffering, can cut to the core of personal and cultural identity. Within the framework of the modern nation-state, the relationships between body, disease, and the social status of doctors often mirror the body politic and call forth nationalist imaginings (Foucault 1975; Haraway 1991; Martin 1997; Adams 1998). In general terms, education—medical or otherwise—is a vehicle by which culture changes and endures. It is also a realm that is often state regulated, and thereby implied in the production of national sentiment and citizenship, within both colonial and postcolonial contexts (Anderson 1991; Comaroff and Comaroff 1992; Chakrabarty 2000). This study of the changes occurring within Tibetan medical education in Nepal and the Tibet Autonomous Region (TAR) of the PRC reveals some of the ways that both Tibetan medicine and a more diffuse sense of Tibetan identity are constructed and experienced within different national contexts. In this sense, my work speaks to other studies of the relationship between nationalism and so-called 'ethnomedicine' or 'traditional healing systems', with a particular focus on Asian healing systems (Farquhar 1994; Hsu 1999; Langford 2002; Scheid 2002). In examining the specific changes affecting Tibetan medical education today, I also draw inspiration from literatures that explore the power of 'science' in shaping national, medical, and individual consciousness (Latour 1993; Prakash 1999; Adams 2002).

This paper illustrates how and why Tibetan medical education is undergoing a number of changes in Nepal and in the TAR. These changes include, but are not limited to: shifts from private, informal instruction, often tied to a particular medical or religious lineage (*rgyud*), toward institutionalisation and standardisation of curriculums; increasing specialisation of Tibetan medical knowledge, precipitating a separation of those who produce Tibetan medicines from those who prescribe them;[2] pressure by governments, non-governmental organisations, and patients, as well as from students and practitioners of Tibetan medicine themselves, to integrate Tibetan medicine and biomedicine, both within medical education and clinical practice; shifts in the sources of funding for Tibetan medical education, including issues surrounding government recognition of, and support for, *gso ba rig pa*;

[2] This theme is also linked to the growing national and international Tibetan pharmaceutical industries (TIN 2004).

and shifts in the roles and responsibilities of Tibetan medicine practitioners. This professionalising process involves conceptions of medical authority and the relationship between teacher and student, doctor and patient, as well as changed expectations about what social, economic and even karmic fruits a Tibetan medical education will bear for those who choose this path.

I place particular emphasis on curriculum. The issue of curriculum —what and how to teach, whether or not to introduce biomedicine into Tibetan medical courses, what the relationship is between standardised programmes and more fluid (though not necessarily less organised) master-apprentice pedagogy—plays out at the level of large, state-supported institutes for Tibetan medicine in the PRC, Mongolia, Bhutan, and India. But these issues are also having crucial impacts on smaller schools and private teachers and students of *gso ba rig pa*, both within the TAR and in Nepal. In relation to this investigation of curriculum, I explore ideas about conceptions of medical and social efficacy, as well as a phenomenon that might be called a 'crisis of confidence' in amchi (Tibetan medicine practitioners) and Tibetan medicine.[3] Each of the trends I identify also involves examinations of the concept and currency of lineage. I attempt to show how conceptions of lineage function within networks of practitioners, between amchi and their patients, as well as within specific nation-state contexts. I also address some of the impacts that biomedicine and Western scientific models of knowledge transmission are having on *gso ba rig pa* medical education.

BETWEEN NATIONAL STRUGGLE AND LOCAL DUTY: AMCHI MEDICINE IN NEPAL

Founded in 1998, the Himalayan Amchi Association (HAA) is a Nepali non-governmental organisation (NGO) that comprises more than 100 amchi from Nepal. This relatively new professional organisation has a variety of long-term aims, including raising the standards and quality

[3] Although 'amchi' (alternative spellings: *am chi, em chi, im ji*) is actually a word of Mongolian origin, it has come to be the primary marker of people who identify themselves with *gso ba rig pa*, particularly in Nepal and Ladakh. Other popular words for 'doctor' include *sman pa, lha rje*, etc. I'm using the term 'Tibetan medicine', but I recognize that this designation of practices as inherently or exclusively 'Tibetan' is not accurate. Hence, I often choose the term *gso ba rig pa* to refer to these diverse manifestations of a system of medicine that shares philosophies and practices.

of health care that amchi are able to provide to their communities, conserving medicinal plants, improving amchi educational opportunities, and networking with amchi in other parts of the Himalaya and Tibet. The HAA was born out of the varied challenges facing amchi in Nepal: lack of state support for *gso ba rig pa*; incrfeasing constraints on access to *materia medica* due to the (legal and illegal) commodity trade in medicinal plants; unreliable state health care services and providers in the communities amchi serve; and, over the past decade, the social, environmental and economic impacts of civil war (Craig and Bista 2005; Craig in press).[4]

The organising and lobbying efforts of amchi in Nepal exist within contested national politics, at a particularly vulnerable time in Nepal's history (Craig in press). Because amchi in Nepal can be considered culturally Tibetan, they are minority Nepali citizens. They live within the world's only Hindu polity, poised between Nepal's *janajāti* (ethnic politics) movement—particularly those ethnic groups who identify as Buddhist—a regional sense of Tibetan identity, and a more local sense of self (Gellner *et al.* 1997; Ramble 1997; Tamang 2000; Craig 2002). This positionality becomes strikingly clear in the language amchi use to describe themselves and their practices. Due to Nepal's geo-political position *vis-à-vis* China and India, and the nation's pro-China stance on the 'Tibet Question' to more homegrown prejudices about its 'Tibetanid' populations (Höfer 1979), practitioners of *gso ba rig pa* in Nepal have identified themselves through the term 'amchi' and 'amchi medicine' as opposed to the signifier 'Tibetan medicine'; hence the name of their professional organisation. This framing of their practices without reference to the term 'Tibetan' can also be said to reflect a desire by practitioners themselves not to be absorbed into the identity politics of Tibet-in-exile. Within the specific context of Nepal, this fraught connection to things Tibetan, and to 'Tibetan medicine' is further complicated by the fact that Āyurveda is both recognised and supported by the government. The HAA has been under internal and exter-

[4] Since 1996, Nepal has been enmeshed in a military and political conflict between the Communist Part of Nepal (Maoist) and the Nepali state, including the Armed Police and the Royal Nepal Army. At this writing, more than 13,000 Nepalis have died in this civil war. Human rights abuses by both the Maoists and the Nepali security forces have been egregious and excessive. Although most of the high mountain regions in which amchi live and practice medicine have not been sites of direct military conflict, this political crisis has impacted their ability to collect and trade for *materia medica*, to earn off-farm income, and to travel.

nal pressure to align itself with institutions of Āyurveda, as a channel through which to gain government recognition. However, this strategy also requires a diminishing of the differences between *gso ba rig pa* and Āyurveda. It also plays on Nepal's *janajāti* politics as well as a sense of what has been called Nepal's 'internal colonialism' (Holmberg, March *et al.* 1999; Gellner 2002), in that it requires the submission of a practice connected to Tibetan Buddhism under the culturally Hindu banner of Āyurveda. Framed within this identity politics, amchi in Nepal face a number of critical challenges in terms of the future of their practice. Historically, amchi in Nepal were educated within a master-apprentice framework emergent from lineage: knowledge was transmitted from father to son, uncle to nephew, or from guru to disciple. However, a variety of socio-economic forces such as an increasingly monetised economy and concomitant out-migration from high mountain villages, as well as the introduction of biomedicine through state and non-governmental channels and the discourses of 'science' and 'development' in Nepal have all had an impact on the course of amchi education and practice, often curtailing young people's motivation or ability to study as did their fathers and grandfathers.

Despite a current interest in ethnomedicine, the state-development apparatus still focuses on incorporating such healing systems as 'complements' to biomedical health care, rather than as valid systems in their own right (Pigg 1995, 1997; Adams 1998, 1999). This bears directly on amchi practice, in both historical and contemporary terms and is directly related to the pressures—both internal and external—that are pushing these doctors to become professional. And, inasmuch as *gso ba rig pa* relies on Himalayan natural resources, this professionalisation is also influenced by national, regional, and international conservation efforts aimed at documenting, preserving, and cultivating medicinal plants (Lama *et al.* 2001; Aumeeruddy-Thomas *et al.* 2002). And yet, in Nepal the plight of *gso ba rig pa* is often couched in specifically cultural—as opposed to medical—terms. The need to 'preserve amchi tradition' is espoused both in government rhetoric in response to the HAA's organising efforts, and by the HAA itself—albeit with different tenors. The ideas of 'cultural preservation' and 'tradition' are often stressed over what could be dubbed the 'scientific' elements of amchi knowledge, particularly in the context of the amchi's struggle for government recognition.

As HAA members contemplate the future of their practice, they see the adoption of more 'Western' or 'modern' modes of knowledge transmission as inevitable, if not completely positive. Not only is learning standardised in 'textbooks' and 'curriculum' comprehensible to the Nepali nation-state, particularly the ministries of health and education, but they are also the models by which elite institutions of Tibetan medicine in India and China have positioned themselves, thereby setting a certain standard for what 'traditional Tibetan medical education' is and means in a modern milieu. Such adoption of the forms of modern, Western education by non-biomedical practitioners and institutions is a common feature within the histories of many so-called 'traditional' medical systems. Of direct relevance to the history and practice of *gso ba rig pa* are the ways that knowledge transmission within contemporary Āyurveda and Traditional Chinese Medicine (TCM, Chin. *zhongyi*) has followed similar trajectories (Leslie 1973; Farquhar 1996; Hsu 1999; Langford 2002; Scheid 2002). Often, the process of adopting models of medical pluralism, which at once valorise and undermine non-biomedical knowledge and practice, is tied directly to the process of articulating and imagining what it means to be a part of a modern nation-state. However, while some of these issues have been an active part of reshaping 'traditional medicine' in India and China since the late 19th and early 20th century, as the HAA Chairman stated, "This concept is new for us".

One of the challenges for amchi in Nepal is the issue of qualification and certification. Although privately taught students and those studying at Nepal's four institutions of *gso ba rig pa*[5] are required to master Tibetan language, most have not passed, and will not be able to pass, the national School Leaving Certificate (SLC) examination, which is based on mastery of Nepali and, to a lesser extent, English. In contrast, those students from Nepal's culturally Tibetan regions who have enrolled in urban boarding schools—including the sons and daughters of amchi—are often illiterate in Tibetan, although they might be able to

[5] The four schools of *gso ba rig pa* education in Nepal are the Lo Kunphen School and Mentsikhang in Lo Monthang, Mustang, the Tibetan Medical Center in Jharkot, Mustang district, the Shelkar Tibetan Medical Institute, Boudha, Kathmandu, and the School of the Four Sciences of the Early Tradition in Dhorpatan, Baglung district (for the latter, see Millard 2002). All four schools admit both girls and boys, and the Jharkot and Boudha schools are explicitly associated with monasteries (Sa skya and Dge lugs, respectively), while the Dhorpatan school is associated with Bon. None of the four schools receive state support or accreditation, and are instead run by a combination of individual donations and NGO support.

pass the SLC. In other words, those students who have remained in their home villages or within a cultural and educational context that provides a solid foundation for the study of *gso ba rig pa*—and who might feel more inclined to serve their home communities upon completion of their training as amchi—often occupy a marginal place within the Nepali educational system, with no recourse to official state certification, let alone medical licensing. Yet students who have left their mountain homes in search of a more 'modern' education are often unable to meet the basic criteria of Tibetan literacy to *gso ba rig pa* upon graduation from secondary school.[6] This catch-22 also bears on the ability for young people from Nepal to qualify for the seats reserved at the Men-Tsee-Khang in Dharamsala for people from what the government-in-exile calls 'border populations'.[7] As such, one of the key points of negotiation and struggle for amchi in Nepal is the creation of government-approved curriculums that are also flexible, acknowledging the realities and limitations of rural Nepali education, and allowing students to move through levels of *gso ba rig pa* training and at the same time earn the equivalent of an SLC. Given the lack of current government recognition of *gso ba rig pa*, questions about who should authorise and certify amchi expertise arise: the ministries of health and education? The Āyurveda Council (within the Ministry of Health)? The HAA? The Men-Tsee-Khang?[8] Or a combination of all of these players? Most importantly, perhaps, are larger questions about how and

[6] The introduction of state-approved Tibetan-medium teaching in Nepal has been slow and politically charged, only making policy headway after the 1990 constitution's recognition of Nepal as 'ethnically, linguistically, and culturally diverse' which allowed for 'mother tongue' education. A number of schools in urban Nepal teach Tibetan, and draw students from the same districts where the HAA draws its members. However, the social pressure to master Nepali and English, as opposed to Tibetan, is felt among students, parents, teachers, and administrators.

[7] The Tibetan Medical and Astro Institute—i.e. the Men-Tsee-Khang (Sman rtsis khang)—requires that students pass an entrance exam, which students with good Tibetan language abilities and a basic introduction to the theories and practices of *gso ba rig pa* could conceivably pass, even if trained in a 'traditional' master-apprentice model. However, the Men-Tsee-Khang and other institutions of higher *gso ba rig pa* learning in India also require that students considered for admission have state-authorised secondary school credentials. It is also interesting to note that, by 'border populations' the government-in-exile is referring to a historical and nationalistic sense of 'greater Tibet' that does not reflect current nation-state boundaries.

[8] In India, the highest authority for Tibetan medical education remains the Dharamsala Men-Tsee-Khang. Although accredited courses of *gso ba rig pa* are offered through the Chagpori (*Lcags po ri*) Medical Institute in Darjeeling, as well as the Central Institute of Buddhist Studies and the Ladakh Society for Traditional Medicine (LSTM) in Ladakh, examinations are set and certificates granted in accordance with Men-Tsee-Khang standards and policies.

where graduates of Nepal's amchi institutions will, or will not, make a place for themselves within private practice and/or national heath care structures. HAA members recognise that without curricula that are state approved and accompanying certification, it will be close to impossible to gain state support for clinical practice of amchi medicine. Yet, they also face the challenge that they are lobbying a failing state, amidst deep social and political crisis.

From Practised Devotion to Professional Degree: Tibetan Medical Education in Tibet

It is impossible to separate the changes that have befallen Tibetan medicine in contemporary China from the rise of the Chinese socialist state and the subsequent health care policies it has implemented, as well as the ways the PRC has classified and controlled its 'minority nationalities' (Chin. *minzu*) and at the same time valorised ethnomedicine, particularly Traditional Chinese Medicine (TCM, Chin. *zhongyi*) (Adams 2001; Janes 2001). China's 'barefoot doctor' approach toward health care was an attempt by the newly formed PRC to officially sanction cultural diversity through its support of medical pluralism.[9] These policies built on a history in which ethnomedical practices have existed in dialogue and sometimes conflict with biomedicine since well before the founding of the PRC.[10] However, it is important to note that this official tolerance of medical pluralism and, by implication, cultural diversity, was also coupled with an equally strong need to control the population, particularly minority regions. As in other moments and places in history, medicine provided a key way to do just this. The 'science' inherent in *gso ba rig pa* has been both a blessing and a curse over the last five decades, as have the historical and mytho-historical connections between TCM and Tibetan medicine (Janes 1995; Adams 1999). These medical systems share aspects of their pharmacopoeia, as well as some diagnosis and treatment techniques. This shared knowledge has been folded into nationalist narratives of the PRC and can be seen as one reason why Tibetan medicine emerged from the 1950s, 1960s, and 1970s more intact than many of Tibet's other religious and cultural institutions. Tibetan medicine education and practice was rehabilitated

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[9] See Farquhar 1994 and Adams 1999 for more information on this aspect of Chinese medical history.

[10] During the 1920s–30s, practitioners of *zhongyi* came under attack by biomedically trained Chinese physicians who tried to outlaw *zhongyi* practice while at the same time capitalise on traditional Chinese medicines. This resulted in widespread protests by *zhongyi* practitioners and the establishment of state support for TCM. See

more quickly than Buddhist ritual or many folk practices designated as 'superstitious'. However, this is a relative statement. Tibet's historical position *vis-à-vis* China, as well as the relationship between Buddhism and *gso ba rig pa*, made Tibetan medicine more 'risky' than other ethnomedical practices among China's officially recognised 56 nationalities. Connections between Tibetan medicine and Tibetan Buddhism posed a fundamental problem for the Chinese state.[11]

Reforms during the Cultural Revolution attempted to distil those parts of Tibetan medicine the state viewed as practical and 'scientific' on the one hand, and to purge those practices deemed 'religious' on the other (Adams 2001). In practice, this meant the retraining of Tibet's physicians to serve the masses, imprisonment for some highly adept *gso ba rig pa* practitioners or the driving underground or into exile of others. Tibetan medicine continued to be taught and practised during the Great Leap Forward and the Cultural Revolution, under compromised circumstances: private practice and instruction were suppressed or only pursued secretly, while sanctioned education was stripped of links to religious practice and to medical theory (Adams 2002). This has meant that a generation of amchi educated at state institutions during this time were denied a full *gso ba rig pa* education—a fact that bears on current generations of students. Yet, since Tibetan medicine was already a state-supported enterprise under the pre-1959 Tibetan government, and since formal and informal exchanges between Tibetan and Chinese medical practitioners had been occurring for decades, if not for centuries, Tibetan medicine was never stripped of its state endorsement. Later, during the period of reform and 'opening up' after 1980, Tibetan medicine received significant state support. Within the TAR and other culturally Tibetan regions of the PRC, Tibetan medicine has been integrated into health care policy and services at the village, township, county, and prefecture levels since the 1980s.[12] Yet this state

[11] Here we see how the logic of China's occupation of Tibet bears the marks of a colonial model, in that indigenous knowledge systems have been valorised and incorporated into the new nation-state on the one hand, and viewed as threatening to goals of modernisation and nation-building on the other. This logic is particularly significant when one looks at the ways Tibetans themselves began to reject—or were made to renounce—Tibetan cultural forms marked as 'traditional' in order to signal their entrance into Chinese modernity.

[12] A number of county and prefecture level hospitals, medical factories, and teaching institutes exist in the TAR and in Kham and Amdo, particularly in and around Derge, Chamdo, Xining, and Labrang, as well as the Kongpo and Nagchu regions of the TAR. The Central University for Nationalities in Beijing also includes a Tibetan Medicine Institute, within the College of Life and Environmental Sciences. The Mentsikhang and the Tibetan Medical College, both in Lhasa, are hubs for education and clinical practice.

support has always come with a price—a set of pressures that are very different from those felt in Nepal.

In terms of education, a glance at the Tibetan Medical College in Lhasa is illuminating. The College includes a clinic and a medical factory, and has approximately 200 students.[13] It offers several types of degrees and courses.[14] The standard curriculum lasts five to six years and includes study and memorisation of the *Rgyud bzhi* and other classical medical texts,[15] but also requires that students are literate in Chinese and also introduces them to principles of biomedical anatomy and physiology. The curriculum also exposes students to clinical diagnosis as well as plant identification and preparation of medicines; most programmes include summer trips to rural areas to identify and gather plants. Historically, students at the pre-1959 Mentsikhang and Chagpori institutes were expected to also have pharmacological expertise, sometimes devoting up to three years of their training just to pharmacology. However, this aspect of medical education, as well as spiritual training, no longer garners the same institutional support in Tibet.[16]

The path of becoming a Tibetan doctor at the Tibetan Medical College and similar institutions is not much different from that of earning other university and advanced degrees. The structure of this college-level education can promote, by accident or design, a passive learning environment in which the 'right motivation' that defines a religious or ethical rationale for becoming an amchi is secondary to the concerns of passing exams and finding a job after graduation. Tibetan medical study is one of many professional paths. It is also a path that carries the stigma of being less valued than biomedical education. Students are often channelled into the Tibetan Medical College if they were not able to gain admission to biomedical colleges.[17] Yet education

[13] The College began in 1989 as the Tibetan Medicine College of Tibet University —a combination of the Tibetan Medicine School (estd. 1983), and the Tibetan Medicine Department (estd. 1985). The College became a separate institute under the TAR Education Bureau in 1993.

[14] The College offers a 3-year vocational course (*bdus ra ba*), a 5–6 year Bachelor's degree (*bka 'bcu pa*), and a 3-year Master's Degree (*rab byams pa*).

[15] However, the amount of text that students must commit to memory has decreased over time, marking a shift in not only how students learn, but also how they retain and draw on theoretical knowledge during clinical practice.

[16] The same is true in exile institutions such as the Men-Tsee-Khang, although as a result of distinct social and political pressures, though both inherently connected to ideas about what constitutes a 'modern' life and 'science'.

[17] A similar stigma has been associated with Āyurveda colleges and universities in India (Langford 2002: 113).

at the Medical College does differ from other avenues for higher education in one fundamental respect: it is the only post-graduate course in which the primary language of pedagogy remains Tibetan, as opposed to Chinese. However there is an increasing emphasis on biomedicine and a need for Chinese linguistic competence. This reflects a future vision of Tibetan medicine in which the medicines themselves, as well as processes of diagnosis and treatment, are seen as scientifically on a par with—or able to mimic—biomedicine (c.f. Adams 2001; Langford 2002). One of the most striking elements of this state-supported education structure is the way that it is creating a generation of Tibetan physicians who are theoretically adept and quite specialised in their knowledge, but who do not necessarily have a practical understanding of Tibetan materia medica or clinical experience, but who are sent out to practise nonetheless, often with poor results.

MODES OF KNOWLEDGE TRANSMISSION: TEACHING *GSO BA RIG PA* IN NEPAL AND TIBET

In order to compare modes of knowledge transmission between Nepal and Tibet, I focus on two private institutions: The Lo Kunphen Mentsikhang and School, one of the four small schools of *gso ba rig pa* in Nepal, and the Pelshong (Dpal shong) School, one of nearly a dozen of such institutions in the TAR.[18] These schools have not taken the place of continued private, informal, master-apprentice practice either in Nepal or Tibet, but they represent a growing trend toward institutionalisation. Their stories illustrate how the meanings and functions of lineage (*rgyud*) are changing, and also related challenges and potential benefits of interacting with both state and foreign collaborators. They also point to the differences in historical and political circumstances between Nepal and Tibet and reveal something of the impacts of state neglect, on the one hand, and state domination, on the other. Beyond the realm of politics, however, the fact that Lo Kunphen is continuing

[18] Other such institutions or *gso ba rig pa* programmes in the TAR include the Choyin Dorje Traditional Tibetan Medical School in Dar chen, Ngari Prefecture, and the Trace Foundation-funded programs in Nagchu Prefecture. A number of other programmes in Tibetan medical education and clinical practice in the TAR and other Tibetan areas of the PRC are supported by NGOs such as Seva Foundation, Tibet Foundation, The Bridge Fund, The Tibetan Healing Fund, Rokpa International, and the Project to Strengthen Traditional Tibetan Medicine.

successfully today, though it has yet to graduate a cohort of students, and that after graduating two cohorts of students Pelshong was closed in 2003, reveals a number of other issues about the ideals and realities of so-called 'traditional' *gso ba rig pa* education today, and gives two strong examples of how and to what extent master-apprentice models can be adapted to suit small-scale institutions.

The Lo Kunphen School and Mentsikhang, located in Mustang District, Nepal,[19] is run by two brothers, both of whom are respected medical practitioners—lineage holders in the line of royal physicians and astrologers of Lo. In 1993, they started Lo Kunphen as a clinic, and registered it as an NGO with the Nepali government. In 1998–99, after the death of their father, and taking in his advice and concerns about the future of *gso ba rig pa* in Mustang, they decided to open a school. Their vision in establishing the Lo Kunphen was

> to ensure the continuation of the ancient tradition of Tibetan Medicine in Mustang; to provide medical service for the people of Mustang; and to provide training and professional opportunities for young people from poor families (Bista 2003).

Lo Kunphen combines academic and clinical training in Tibetan medicine with a curriculum of Nepali, Tibetan, English, and mathematics for its more than 25 students, ages 13–20, more than 50 percent of whom are girls.[20] The students are divided into two main cohorts: an elder group of 12 students all of whom entered the school with at least a class five education in the Nepali school system, and a younger cohort of students from particularly poor families who would otherwise only have recourse to accessing the poor quality, and non-Tibetan language medium, Nepali schools. The curriculum also includes *gso ba rig pa* instruction based on the *Rgyud bzhi* but inclusive of teachings from Mustang's medical lineages (through oral instruction and extant medical texts), as well as religious and ethical education. The brothers teach primarily from two readers and one prayer book they designed, which

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[19] Mustang district is located in the rain shadow of the Himalaya, bordering Tibet. The approximately 7,000 inhabitants of northern Mustang (Baragaon and Glo stod tsho bdun) speak dialects of Tibetan, practise Buddhism (Rnying ma, Bka' rgyud, and Sa skya schools) and Bon. Local health care needs are met primarily by amchi, although there is a district hospital in Jomsom, and a few marginally functional government health posts at Village Development Committee (VDC) levels.

[20] This latter fact represents a great shift within amchi practice in the Nepal Himalaya, which has historically been the province of male practitioners.

include key chapters in the *Rgyud bzhi* as well as details on plant identification, collection, and preparation of medicines; they also teach from treatises on Lo's medical history and medicinal plants written by their father before his death. No biomedicine is currently taught at the school. Attached to Lo Kunphen is a small medicine factory and a clinic. Students are intimately involved as apprentices in both endeavours and practical experience is viewed as an essential part of the Lo Kunphen curriculum.[21] The Lo Kunphen founders consider their curriculum to be geared toward local clinical practice but they also feel that the brightest students would benefit from further formal study, preferably in Dharamsala or Lhasa. Their programme lasts five years, followed by a commitment by each student to practise and gain clinical experience for at least two years under supervision by an experienced local amchi, at Lo Kunphen branch clinics or in private settings in their home villages.

Lo Kunphen has received support from international foundations and individual donors, but has received no support from the government of Nepal.[22] The amount of money generated by the Lo Kunphen clinic is small. It is becoming easier for amchi to charge fees for medicines themselves, as Mustang's population becomes more imbedded in a cash economy. Yet older cultural expectations play out between amchi and their patients: there is no set fee for medical service or medicines, and amchi often accept what they are given. The brothers believe that without Nepali government recognition of and support for amchi medicine, it will be very difficult to maintain Lo Kunphen in the long-term. Although they have been able to make a living as private practitioners, they fear this will not be possible for their students. These local concerns inspire their involvement in the HAA and other regional affiliations.

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[21] Lo Kunphen has also begun cultivating medicinal plants, training some villagers as medicine-makers, and establishing a small herbarium, thereby trying to promote sustainable harvesting and use of materia medica and providing local employment. As is the case for most amchi in rural Nepal, many of the ingredients Lo Kunphen needs to produce medicines can be collected locally, but the institution still spends approximately Rs 100,000 each year on the purchase and transport of raw materials and ready-made Tibetan medicines available in Kathmandu.

[22] The majority of funding for Lo Kunphen has been provided by a British charity, KINOE (Kids in Need of Education). The amchi's family donated the land for Lo Kunphen. Students' families contribute food, clothing, and fuel.

In the TAR, a school for Tibetan medicine just outside Shigatse, at Pelshong, was created with financial support from the Swiss Red Cross and authorisation from the TAR Health Bureau and relevant Shigatse Prefecture authorities. The buildings that comprise Pelshong once housed an army camp, but were transformed into a lovely expression of Tibetan aesthetic: the main classroom decorated like a prayer hall, with medical thangka lining the wall. The school opened in 1990, under the direction of a senior amchi from Shigatse. Before joining Pelshong he was the director of the Traditional Tibetan Medicine section of the Shigatse Municipal Hospital. The explicit aims of Pelshong—to improve rural health care in Shigatse Prefecture through training Tibetan doctors and to aid in the preservation, transmission, and utilisation of Tibetan medicine—mirror the goals of Lo Kunphen, despite the historical and political differences between Nepal and Tibet. Indeed, both institutions can be seen as a response to economic, political, and social change—the fears and realities of a decline in *gso ba rig pa* knowledge and practice.

The first batch of 36 students at Pelshong, and the second batch of 54 students were recruited by the director in 1990 and 1999 respectively, and were graduates of primary schools in Shigatse prefecture. Some came from amchi lineages; unlike Lo Kunphen, all were young men. The first batch of students studied for six years along the lines of a 'traditional' curriculum that was based on memorisation of medical texts[23] and some limited practical training in plant identification and medicine production under the director's guidance, and included no biomedical component. After they graduated, the curriculum went through a series of reviews and revisions over a three-year period before the second cohort entered the school, under a revised four-year curriculum. In addition, based on recommendations from evaluators of the school the Swiss Red Cross supported a six-week introduction to biomedicine for the first cohort of students three years after they graduated. In addition to Tibetan medicine, students were also instructed in Tibetan language, but in line with the director's vision, they were not instructed in Chinese. Upon graduation, students received a school diploma but not a medical licence by the Shigatse Prefecture Health Bureau.

The two cohorts of graduates from Pelshong are now practising on their own, without certainty of further support from the Swiss Red

[23] Primarily the *Rgyud bzhi*, along with the commentaries of Desi Sangye Gyatso, The Blue Lapis Lazuli, and Amplifications.

Cross or the government, and often without further connection to their classmates or other practitioners. A few have taken up apprenticeships with senior amchi in Shigatse, arranged either through the director's contacts or through Swiss Red Cross connections. Some are spending a year at Shigatse Prefecture hospitals, getting a crash course in maternal and child health, epidemic prevention, and basic biomedical public health and few will have an opportunity for further clinical practice and study at the Lhasa Mentsikhang; but most live and work in their rural communities, attempting to make a place for themselves locally, within or outside the state Cooperative Medical System (CMS).[24] Although the school had, at times, been a showcase for this European aid organisation, Pelshong as a model institution for contemporary Tibetan medical education has been deemed a disappointment and, at worst, a failure. The school was begun with the hope that novice amchi trained at this school would provide health care at a local level. But after the first class was graduated, many of the novices were having trouble surviving as amchi and a few had quit practising altogether; many had turned toward practising both biomedicine and Tibetan medicine—even though they had received no biomedical training. When asked about this situation, many sited a lack of confidence in their own abilities, scanty clinical training, lack of access to Tibetan medical supplies and an inability to make their own medicines; many cannot compete with the cost of health care provided by the (primarily biomedical) CMS system (Heimsath 2004). Others described encounters with patients who would rather have an IV antibiotic drip than a Tibetan medicine pill (*ril bu*) and who equate health care with the instant, powerful allure of biomedical treatment as it is administered in the TAR (*ibid.*). In addition, as novices with often little connection to a lineage-based practice or to biomedicine, local patients who still might seek out an elder amchi are often skeptical of the Pelshong students' abilities. Some Pelshong graduates are doing well and committed to practising Tibetan medicine; others simply don't have a strong enough connection to the

[24] The Cooperative Medical System (CMS) is the state health insurance system, a recent introduction into rural Tibet. Individuals contribute approximately 10 yuan per year, which is supposed to entitle them to a 40–70% subsidy on medical care. In practice, confusion and mismanagement pervade this system, although the system has brought an increase in the kinds and amounts of biomedical drugs available at township clinics and county hospitals.

community in which they are now practising, and lack motivation, ability, or authority to practise as a result.

Lo Kunphen and Pelshong share many notions of what a *gso ba rig pa* curriculum should entail, yet the aims of their curriculum and teaching methods differ greatly—with a direct impact on the success or problems facing students at both institutions. Although the director of Pelshong taught along the lines of a master-apprentice model, he did so with a group of students that was much bigger than that which would have been taught by one master historically. Kunphen, in contrast, has two *gso ba rig pa* instructors in the two brothers and they have also sought out other amchi from Mustang and beyond to teach their students. Likewise, both schools do not teach biomedicine—for both practical and philosophical reasons. However, given great differences in the realities of state health care and patient demands for biomedicine in Nepal and Tibet, this curricular choice has different implications.

On the question of language acquisition, the schools also differ fundamentally in their approach. It can be said that both schools are operating under the constraints of a colonial system in the ways that Chinese and Nepali are languages imposed by the state and also crucial to social advancement, while Tibetan is marginalised in both contexts. Yet, while the brothers who founded Lo Kunphen believe that not only Nepali, but also a basic knowledge of English, is fundamental to their students' future opportunities, the Pelshong director saw Chinese as unnecessary, or counter to the school's goal of preserving Tibetan culture. While Lo Kunphen students will hopefully be able to negotiate a place for themselves within or between state health care and private practice, Pelshong graduates are inadequately prepared to interact with a health care system in which the principal language is Chinese. On a related note, these two schools differ fundamentally in terms of the relationship they would like to forge with the state. Lo Kunphen sees its future success as linked directly to garnering some level of state support. The brothers would view their endeavours as a success if they were able to place their students at government health posts, where they would function alongside biomedically trained health workers, or get some basic biomedical training themselves and serve a local community. In contrast, one of the initial stipulations in the founding of Pelshong was that students would commit to practising outside the state health care structure. However, in reality, this has served to marginalise many Pelshong graduates and undermined their ability to practise. One of the

great differences between these two institutions is the integration of theoretical *gso ba rig pa* knowledge with practical, hands-on experience. Although the Lo Kunphen students are, on average, five years younger than students at Pelshong, they have been exposed to much more clinical practice. And although the number of medicines they can make are limited, they still produce their own medicines with local ingredients, for local use—in marked contrast to Pelshong graduates, none of whom produce their own medicines.

PLAYING THE 'CULTURE CARD' AND PUSHING 'INTEGRATION': NGOS, STATES, AND BIOMEDICINE

It is worth considering the relationship between state and non-governmental support, and the impacts of this support on the medical schools' outcomes. As we have seen, many small schools and training programmes of Tibetan medicine have been established in the TAR and Nepal, and are being funded by international non-governmental organisations. Given the Chinese state's strict stipulations on, and concerns with, foreign involvement in the TAR, as well as the demands for 'local partners' and 'accountability' as part of foreign aid, NGOs in the TAR are, for the most part, required to work with prefecture-level as well as local (village, township and county) government. In this respect, even though NGOs can be classified as a 'third sphere' or a 'network', the reality in Tibet is that they still work within strict state regulations and agendas that are often driven by complex negotiations between state representatives and foreign donors. However, private foreign aid is often garnered for such endeavours in Tibet by playing the 'culture card': by supporting a Tibetan medical school or clinic donors in the UK or US feel they are contributing to the survival of Tibetan culture under the circumstances of 'occupation' and culture change. Yet what it means to support Tibetan survival, particularly in the realm of medicine and health care in the TAR, remains open to debate.

The Nepali state, on the other hand, maintains a longstanding alliance with, and dependence upon, foreign aid (Des Chene 1996). After the demise of the Rana regime in 1951, the centralised Panchayat government introduced biomedicine to Nepal on a broad scale, with capital and expertise provided by foreign aid organisations (Justice 1986). This trend has continued in the wake of Nepal's 1990 revolution,

with connections made by government, civil society, and aid organisations between the assumed neutrality of science and biomedicine, the universal applicability of democracy as a mode of governance, and the goals of development (Adams 1998). The introduction of health-related development programs marked a watershed moment in conceptions of 'belief,' 'science,' and medical efficacy, in both local and national Nepali discourse (Pigg 1996). Even today, much of the authority to create and actualise development policy exists in a realm where the boundaries between state and development agency are porous, in flux, and sometimes tied to ethnic projects (Bhattachan 1995).

Many of these schools and training programmes are an attempt to provide educational opportunities that valorise and adhere to Tibetan culture in general and medical knowledge in particular. Yet many of these schools and programmes also attempt to prepare students to practise medicine in rapidly changing social, economic and political contexts—with greater and lesser degrees of success. More and more schools or educational programmes funded by NGOs are premised on, or have begun to adopt, 'integrated' curricula, in which a more 'traditional' course of study is altered to include biomedicine. This often takes the form of emergency care, maternal and child health skills or the ability to administer intravenous drugs including antibiotics. Part of this shift is dictated by the physical and geographic circumstances in which most amchi work and the lack of quality health care services in such regions. Another reason for the emphasis on biomedical training comes directly from the health care problems faced by many Tibetan communities: tuberculosis, hepatitis A and B, Sexually Transmitted Infections (STIs) and other communicable diseases for which biomedical treatments can be made available. And part of this pressure has everything to do with the power of biomedicine and science: defining paradigms, practices, and belief systems that are far from value-neutral, despite their universalising tendencies.

Paradoxically, although the goals and perspectives of foreign projects might seem to stem from a radically different place than state policies in regard to health care, in either Nepal or Tibet, they can also begin to mirror each other. The power of biomedicine—both in practice and as an ideology about health, well being, and development articulated by bodies from the Lhasa Health Bureau to the WHO—can come to dominate or erase that which is unique about Tibetan medicine in the process of supporting it (c.f. Adams, this volume). The emphasis placed

on 'modern science', including a biomedical worldview, as opposed to 'tradition' and the interesting but still 'backwards' aspects of *gso ba rig pa* is a discourse that surfaces among international NGOs and government agencies, and that can continue to undermine attempts to both support Tibetan medicine and create meaningful and successful programmes in 'integrated' medicine. To a certain extent amchi medicine is construed simultaneously as an exemplar of 'indigenous knowledge' and as a hindrance to 'development' in Nepal and politically suspect in Tibet. Indeed, this can be viewed as a trans-national manifestation of the marginalisation of non-Western sciences and healing systems, bound up within particular political histories and national imaginaries. A growing awareness of the potentially negative impacts of 'integration'—as well as a valorisation of 'traditional' curriculum merely for tradition's sake—has prompted some programmes of Tibetan medicine in the TAR to revamp approaches to education along the lines of some of the approaches we see at play in Nepal: models that are fundamentally geared to a marriage of theoretical learning and practical experience from the very beginning, and that are open to, yet also guarded about, the ways that biomedicine might be incorporated into the curriculum. But it is important to reiterate that pressure to include or incorporate biomedical practice is not only a result of governmental or non-governmental pressure; it is also a force at play in the interaction between doctors and patients, as well as a reflection of changing expectations and understandings of what medicine is and does, what it means to heal and be healed in the Tibetan context.

Conclusion: Lineage, Efficacy, and a 'Crisis of Confidence' in Tibetan Medicine

From both a sociological and an historical perspective, Tibetan medical practice has been structured around lineage-based master-apprentice relationships. For many centuries, Tibetan medicine was not primarily taught through large schools such as the original Chagpori, but rather was a body of knowledge passed down through a combination of oral and literary sources, often connected to lay or religious lineages. In fact, to distinguish the early 'schools' of Tibetan medicine, such as the *byang* and *zur* (Hofer, this volume), from the master teachers who were also key 'lineage holders' is to miss the ways that these modes of knowing Tibetan medicine were—and still are—connected. Yet it is also

important not to create ideal types out of religiously-inclined, lineage-based instruction or more secular institutional learning. While such distinctions are important, and reflect larger social, economic, and political change both within the TAR and Nepal, we should not view these categories as mutually exclusive, either historically or in the present.

Particularly in the TAR, it is neither necessary nor possible for all amchi to act as religious specialists in fulfilling their role as healers. It is also important to recognise that although Tibetan religious and medical practice are philosophically intertwined, they need not be so in practice; indeed many contemporary practitioners of *gso ba rig pa* both in Tibet and in exile stress a separation of religious from medical expertise and have themselves adopted a stance in which *gso ba rig pa* draws its legitimacy from interaction with Western scientific thought and method—for instance a Tibetan medicine's ability to be proven efficacious by the logic of double-blind placebo trials. One sees the effects of this trend within Tibetan medical education, in the sense that people who go through a secular (or otherwise ideologically inclined) secondary education have already experienced a shift in how they conceive of the world—a phenomenology that depends on many of the taken-for-granted binaries such as the distinctions between 'religion' and 'science'. To expect such students to enter into the study of Tibetan medicine and instantly adapt to or embrace a more 'traditional' mode of learning is to be naïve about the extent to which modern educational structures have an impact on modes of thought. In this sense, there is much support, both by state agencies and by amchi themselves, for classifying *gso ba rig pa* as a technical practice in which the 'religious dimension' is not fundamental to successful healing. Within Nepal, this has surfaced through the untranslatability of certain aspects of *gso ba rig pa* education into a language that makes sense to the Nepali government, either in English or Nepali, and therefore the seeming secularisation of what becoming an amchi entails. However, for those members of the HAA who are invested in creating these new curricula, there is an implicit understanding that certain subjects or kinds of knowledge will be taught, but will not be described in the official curriculum plans that they will submit to the government.

By a 'crisis of confidence' in *gso ba rig pa*, I refer to the phenomenon by which Tibetan medicine is viewed through the lens of biomedical conceptions of the body, health, and disease, by practitioners and patients, as well as by the state and international interlocutors; or where

Tibetan medical education is meant to mirror either urban, elite biomedical education or be construed as vocational training with an ethnic marker—a formalisation of 'indigenous knowledge'. This crisis of confidence echoes colonial patterns whereby judgments are passed on bodies and forms of knowledge that render this knowledge as 'tradition' waiting to be put to the use of modernisation or, in some cases, purged from national memory. Yet the nature of this 'crisis' is also an example of what Jean Langford has dubbed 'postcolonial imbalance' (2002). Namely, the need to recoup 'tradition' as a site of authenticity and national pride, as a way of rectifying the ills of modern life. Indeed, we could see this need to defend and yet transform so-called traditional practices as a fundamental component of what it means to be modern (Appadurai 1996). And, in each national context, we see the play of both colonial models of governmentality and the neo-colonial tendencies that often characterise international aid (Ferguson 1990; Marglin 1990; Arnold 1993; Escobar 1995). These conceptions of the crisis of confidence in Tibetan medicine meet, and intermingle, in the planning and execution of health development policies, as well as in the efforts by individual amchi and collectives of *gso ba rig pa* practitioners to reinvent themselves and their practices under an array of cultural, economic, and political pressures.

This 'crisis' also bears on how lineage is conceived. The efficacy of lineage-based medical expertise often derives as much from a patient's valuation of a practitioners' membership in a *rgyud* as his or her diagnostic skill and medicines. Lineage can also be a gloss for the relationship between a particular socio-physical environment and medical expertise. As in northern Nepal, some lineage amchi in Tibet will specialise in certain kinds of medicines or therapies and will pass on not only this technical skill—such as golden needle acupuncture or bone setting—but also a sense of authority and trust vested in this line of healers. Likewise, others produce medicines whose potencies are tied to a particular sense of sacred geography: the power vested in medicines from a particular place, and to the practitioners from that place. In Tibet, some private amchi have often explicitly disassociated their practices from the Chinese state and have sometimes suffered the consequences. Part of the efficacy of their practice is political in nature: a choice against being absorbed into or restricted by the Chinese health care system, or against making medicines in a 'standardised' way (c.f. Schrempf this volume). This is complicated by the fact that, in both

national contexts, there is a tension between patients who view biomedically-inclined practice as more 'powerful' and those who continue to seek out links to medico-religious *rgyud pa'i am chi* because they view their practice as the most efficacious. Furthermore, sometimes what kind of medicine an amchi practices is not of concern to some patients; rather, they look toward lineage as the main mark of certification. In this sense, efficacy sometimes stems from a sense of social legitimacy and is not necessarily a matter of what an amchi prescribes.

In Nepal many amchi feel that it is important to encourage students who have a family background in *gso ba rig pa*. And yet, there is also a sense that lineage should not be an exclusive reason for admission into any of the existing schools. They recognise that lineage can sometimes function as 'entitlement'—as opposed to skilled practice, deep medical knowledge, or aptitude and motivation for study. In turn, amchi in Nepal associate this reliance on lineage as one factor that has contributed to the decline (*nyams*) of amchi's reputations and socio-economic positions at a local level. For some Tibetan amchi, lineage is also viewed as an 'excuse' for mediocre practice, although the logic behind this sense of ambivalence toward lineage is construed differently given the particulars of political history. Practitioners at both private clinics and state-run institutions in Tibet often say that lineage should not be considered a primary criterion for whether or nor one can become a skilled amchi. Indeed, some Tibetans view this notion as an 'old' way of thinking—one that does not take into account the notion in Tibet's 'new society' (*spyi tshogs gsar pa*) that class or heritage should not determine one's profession. Other amchi cite the inherent bias against women within a lineage-based mode of medical learning and say that this emphasis on private master-apprentice instruction does a disservice to the future of Tibetan women, in their potential as healers, and in relation to maternal and child health care.

In the final analysis, the changes occurring within Tibetan medical education are part of larger movements and pressures to standardise and 'modernise' Tibetan medicine, to garner state and international NGO support, to tap into the transnational interest in 'alternative' therapies, and to allow amchi to survive in market economies. These changes are also a part of nationalist agendas and touch on the places Tibetan medicine can, or cannot, occupy within different nation-state contexts. In a more general sense, the transmission of knowledge means the ability to reinvent and revitalise what is meant by 'tradition', to create webs of meaning that both sustain a culture and incorporate change. In this

sense, the efficacy of medical education is physiological and psychological, social and political. It is worthwhile thinking how this 'crisis of confidence' in Tibetan medicine, and all the social, political and economic challenges it entails, might also hold potential for a renaissance of Tibetan medical education and practice in both national contexts, but also in the spaces between the nation—spaces that amchi on both sides of the Himalaya are beginning to explore and traverse themselves. It is worth asking what might emerge if Tibetan medicine is construed neither as 'traditional' nor 'modern'—exemplified through the ideal types, in a Weberian sense, of lineage amchi or state certified Tibetan physician—but as an essentially fluid set of practices, involving the appropriation and reconfiguration of different modes of learning and knowing, diagnosing and treating, models that might not need to be 'integrated' but that, in combination, allow for a transformation of this medical system without the loss of all that makes *gso ba rig pa* both diverse and unique.

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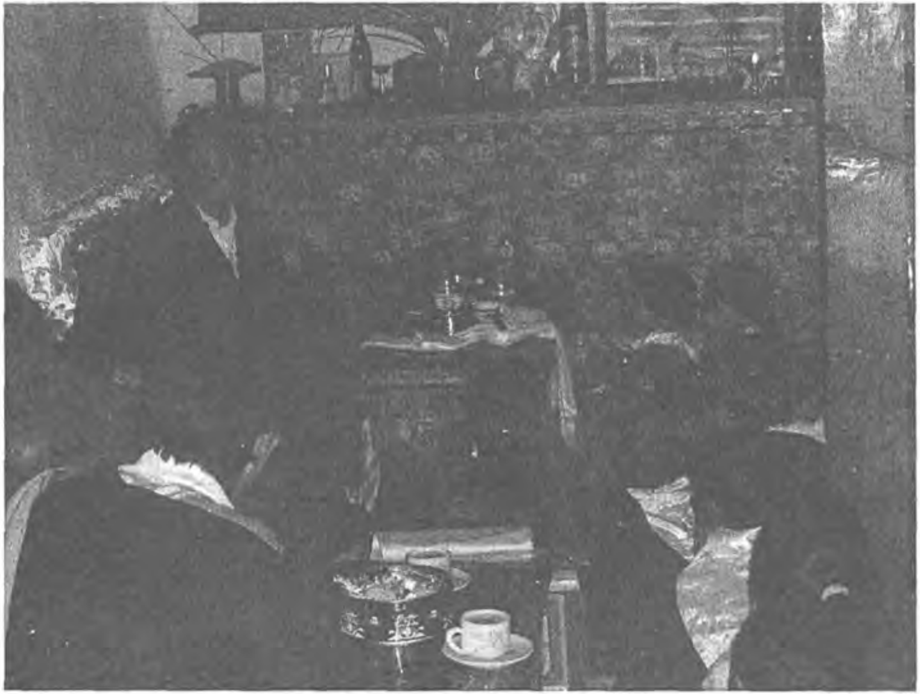

Plate 1: Ralo rimpoche with Lo Kunphen Students: A visiting scholar who came to Lo on religious pilgrimage gives instruction to students at Lo Kunphen.These sorts of "guest lectures" and teaching opportunities are encouraged by the founders of the school

Plate 3: Chokhang instruction—a view inside the now closed Pelshong School outside of Shigatse, TAR. One can see medical thangka paintings displayed in the background

Plate 2: Lo K at HAA—Students from Lo Kunphen registering as official members with the Himalayan Amchi Association (HAA) during the 3rd National Conference of Amchi in Nepal. January 2003

Plate 4: Ingredient displays—Examples of raw medicinals displayed in the main instruction room at Pelshong

Plate 5: MTK Lhasa—Statue of Yuthog Yonten Gompo the Elder outside the Lhasa Mentsikhang

MAKING A MEDICAL LIVING: ON THE MONETISATION OF TIBETAN MEDICINE IN SPITI

FLORIAN BESCH

Most current research on modernisation of Tibetan medicine has been carried out at major centres of Tibetan culture, concentrating on Tibetan medical institutions in Leh, Dharamsala, Kathmandu and Lhasa, as well as in the larger Tibetan settlements in India (e.g. Adams 2001, 2002; Janes 1995, 1999, 2001; Pordié 2002; Samuel 2001). In contrast, this paper is concerned with a highly localised, village-based focus on 'amchi medicine'—as Tibetan medicine is locally called—as it is practised in the western Himalayan valley of Spiti. One aspect of 'professionalisation' of Tibetan medicine will be investigated here by looking at profound socio-economic changes in medical practitioners' works and lives. Villagers now draw a firm line between accepting to pay a certain amount of money for a prescribed medicine and refusing to pay fixed prices for a medical consultation. In other words, while they have come to tolerate a general commodification of Tibetan medicine (and medicine in general), villagers keep resisting the commercialisation of 'traditional'[1] medical services that previously were based upon reciprocal and complex social healer-patient relationships, where an exchange of medical service for labour was the established norm. Consequently, although Spiti villagers as individuals were quick to use the rising money economy for their own purposes, the amchi themselves seem to be unable to participate in it, and now face difficulties making a living. Their predicament is grounded in a combination of state-administered biomedical hegemony, the newly introduced monetary system, and the breakdown of the 'traditional' socio-economic system of reciprocal exchange between amchi and villagers.

This paper, therefore, sheds light on the contradictions and problems of making a living as a rural medical practitioner in present-day Spiti,

[1] Exploring a field that is strongly characterised by a process of change requires that 'tradition' and 'modernity' be viewed not as a fixed binary opposition in which it is the goal for a society to reach a state of 'modernity' in the future. Rather, as is the case in this study, people—here, the Spiti amchi—by using so-called 'traditional' and 'modern' elements alike deliberately try to create a beneficial present, which is consequently very dynamic.

in contrast to amchi in other well-established centres of Tibetan medicine. The complex social rootedness in the exchange of gifts between amchi and their patients will be examined by following Marcel Mauss' analysis of gift and counter-gift, as expounded in his famous work *The Gift* (1954). I will discuss the altruism and the ethical, social and medical obligations of the amchi grounded in their tradition, and their continued socio-medical relevance up to the present day. This chapter is based upon my field research in Spiti from January to June 2003, and on observations dating back to 1999.[2]

SPITI—A REMOTE PLACE

Spiti is not only a remote place geographically and historically speaking, it is also remote in terms of Tibetan medicine.[3] Situated in the high desert landscape of the Himalayas in Northwest India, in a valley with high passes at either end, Spiti has remained largely cut off from trade routes, as well as from social, cultural and religious exchange with its neighbours. Because of its geo-political importance as a buffer zone between India and China since the late 1960s, and also due to its status as a 'tribal area', Spiti has attracted a strong financial engagement by Indian central and state governments aimed at the 'development' of the region. Road building resulted in the connection of nearly all villages with the main Spiti valley (even up to 4,200 m) and brought modernity into most houses, not only in the form of technical equipment, but also as altered dietary habits, patterns of dress, and so on. However, it is only since the 1980s that state interventions have intensified, and only since this time has Spiti undergone dramatic economic and socio-cultural changes. Among many government institutions, primary and sec-

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[2] I am grateful to the Heinrich-Böll Foundation who generously supported my research which is the basis of this chapter. Further, I would like to thank especially Laurent Pordié, Isabelle Guérin, William Sax and Mona Schrempf for their useful comments on the initial versions of this paper. Because my fieldwork is ongoing, the following statements have to be seen as preliminary. Furthermore, the analysis given here is provisional since developments will certainly continue to alter rapidly, given the contemporary course of change in Spiti.

[3] Spiti valley is located south of the Ladakhi Changthang area and the Indo-Chinese border in the Indian state of Himachal Pradesh. The main valley stretches about 130 km from west to east along the Spiti river. Due to harsh weather conditions, the passes to the Indian mainland are closed for about six months of the year. Even within Spiti several villages and some areas are cut off from the main valley from December to May.

ondary schools have been widely established and give today's young people the chance of gaining well-paid government employment. From the beginning of the 1990s, tourism and cash crop (peas, potatoes, apples) cultivation were established and have contributed to the commercialisation of Spiti's society. Because most families receive a cash income in one form or another, money is accepted for any kind of remuneration, and land, labour and goods have become commodities that are bought and sold. It is no exaggeration to suggest that large sections of the local community have a stable income from one or more sources, in addition to their subsistence agriculture and stockbreeding. This private wealth is a relatively recent development which began only at the close of the 20th century, and one that has become apparent in a virtual explosion of the presence of taxis, private cars, entertainment goods like televisions and DVD-players, new construction of guesthouses and private homes, as well as a fully established cash flow in the bigger villages.

Formerly, the economic situation of the practitioners of Tibetan medicine in Spiti was strongly interwoven with the village social structure. All amchi worked mainly as farmers and only part-time as medical practitioners. To ensure that the amchi had enough time for their studies, the collection of medical plants, and the making of medicine, a reciprocal system was in place. To make a living as an amchi one had to rely on the close involvement of the community. The system was balanced although it contained a good deal of power on the amchi's side. Being usually the only option for medical treatment in a village, the amchi held a monopolistic position in local health care.[4] They could give more or less effective medicines to their patients according to the perceived social relationship between amchi and patient (Kloos forthcoming; Kuhn 1988; Pordié 2002). The villagers depended upon their services, especially during the long and harsh winters. Generations ago, many villages in Spiti provided their amchi families with sufficient land and a house, so that the amchi have large plots even today. A mixture of gratitude and moral obligation—which certainly varied individually—ensured that patients remunerated treatments by working in the amchi's fields. Usually, this labour was demanded on three fixed occa-

[4] The monopoly did not include diseases caused by spirits and demons as these were and are more likely to be treated by *chos pa* (tantric adepts), *lhapa* (oracles), or lama. But a strict separation of the spheres of treatment is in practice not possible.

sions during the farming year: planting, harvesting and threshing. At least one member of each family had to first help in the fields belonging to the monastery, and then in the amchi's fields. Only afterwards did people go to work in their own fields. Furthermore, patients provided the amchi with some goods every now and then (Craig 2007; Kloos forthcoming; Kuhn 1988). The 'traditional' reciprocal exchange between villagers and amchi in Spiti is, as Bloch and Parry (referring to Gregory) state in general, "based on an exchange of inalienable objects between interdependent transactors" (1989: 8). This system of securing health care can be viewed as an explicit exchange of gift and counter-gift in the Maussian sense in which each donated object (here goods and medicines) or action (work in the fields) is accompanied by moral obligations on the receiver's side (Mauss 2002 [1954]).[5] However, fundamental to the amchi practice and the amchi's social status is his altruistic attitude. Patients and amchi both express that an amchi should not wish to be compensated.[6]

A Glut of Amchi and the Breakdown of Exchange

To introduce the contemporary conditions of Tibetan medicine in Spiti, I will describe the particular situation of the amchi of the Pin Valley area. Pin is the largest side valley of Spiti, and is cut off from the main valley for at least four months each year due to snowfall. State intervention, including schools and biomedical facilities, dates back to the 1970s and has had a crucial impact on amchi medicine. Until the 1970s, it was customary all over Spiti that medical knowledge was transmitted from teacher to disciple, usually from father to son, in a family lineage (*rgyud pa*). Learning *gso ba rig pa* (literally, 'the science of healing') was based on the memorisation of parts of the *Rgyud bzhi* (the main literary work of Tibetan medicine) and oral instruction by the teacher. The total time of learning differed from student to student, but a minimum of five to six years was seen as sufficient.

[5] I will focus in this paper on the socio-economic consequences of the loss of gift exchange and not on the morality of the gift or the superiority of the donor (see Yan 2002).

[6] This is further consolidated by the fact that the main literary works of Tibetan medicine emphasise that a practitioner of Tibetan medicine has to be compassionate and altruistic (Clark 1995).

In the 1970s, an unusual and somewhat surprising event took place in the Pin Valley: within the space of a few years, approximately 20 young men suddenly decided to learn amchi medicine, although none of them were descendants from an amchi lineage. Within a short time, most villages in Pin, which each have up to about 60 households, had two or three, and sometimes even up to six, amchi. During interviews, the amchi explained this situation by giving the following four reasons:

1) The opening of the first government school made parents think that the government wanted to take away their children, so they preferred to have them educated in a 'traditional' occupation.

2) People saw an advantage in having a practitioner in their own family who secured health care, especially during the long winters.

3) The amchi's work was well respected and gave its carrier a high social status (just below that of the monks).

4) The main reason to take this decision was that parents thought an amchi could make a secure living because the reciprocal system guaranteed that the amchi's time intensive work would be remunerated.[7]

These new amchi students went to one of the renowned lineage amchi of Pin to study first the *Rgyud bzhi* and then the amchi practice. But as the temporary loss of their domestic labour could not be compensated by their families, the students did not live in the teacher's house, or lived there only during winter. Most of these amchi apprentice studied for only two to four years anyway, and these limited years of learning were even more reduced due to the training being restricted to the winters. Later on, when they were working as amchi, they were poorly trained and badly equipped with medicines,[8] but nevertheless were con-

[7] Kuhn (1988) shows explanations of non-lineage amchi for taking the decision to undergo the medical training in Ladakh. Except the first point, they vary considerably from what amchi told me in Pin. They are as follows: parental wish or advice; a meeting with a *sngags pa*, i.e. a 'tantric adept'; or extraordinary experiences.

[8] Tibetan medicine includes a wide range of medicinal raw materials which are either found in the Himalayas or have to be imported from the Indian plains. Spiti amchi collect the local plants, minerals and animal ingredients and buy the remaining ones from Rampur, Shimla or Manali. In addition, the lineage amchi inherit their forefather's stock of long lasting medicinal raw materials. The ingredients are processed into powdered medicine. However, poor training, as among those Pin amchi, causes lack of knowledge about where to find the needed ingredients and how to prepare the medicines.

sulted for different individual reasons. This oversupply of amchi reinforced a more general dilemma facing Tibetan medicine in the whole of Spiti, which was already beginning to take shape.

The state interventions that began in the 1960s included provision of the first biomedical facilities for Spiti. The newly introduced state-sponsored treatments and medicines were freely administered.[9] Although of low quality and only seasonally accessible, they caused an unequal local competition with amchi medicine that increased over the years. Health posts are now present in almost every village and in Kaza, the main town of Spiti, a biomedical hospital has been established. This hospital especially has become the first location at which the population now seek health care services during summer, since it is within easy reach for everyone at that time of year. Biomedicine incorporates two fundamental advantages over amchi medicine: first, it promises a fast cure and therefore corresponds to the patients' lack of time during summer, when everyone is busy working; and second, it is free of cost and any subliminal feelings of guilt.[10] During winter, patients have more time free from the demands of work and are able to follow the longer courses of Tibetan medicine, and roads closed by snow again renew their dependent relationships with the amchi.

With the development of a modern infrastructure and the market economy, social ties in Spiti were gradually loosened and individualism grew, as people moved out of their villages towards Kaza or went for education to the Indian plains. The reciprocity that had been embedded in the social system to provide for certain community tasks broke down in almost all parts of Spiti life, including the sphere of amchi medicine. Payment has replaced exchange almost everywhere, and the introduction of money as remuneration is now pervasive in everyday life. Even the monks who perform rituals on many occasions throughout the year now receive money for their services. Yet, there is no general consensus that amchi should receive donations. In some rare cases, depending on the relation between amchi and a community, villagers might give donations in form of money for received medicines. Usually, however, people just stopped supporting their amchi altogether throughout Spiti. The traditional system of counter-giving (Pordié 2002) had been under-

[9] Because Spiti is recognised as a 'tribal area', the fee for consultation and treatment at the government hospital or a primary health care center is only 25 Paisa (100 Paisa = 1 Rupee; 55 Rupees = 1 Euro in 2003).

[10] I will explain the psychological uneasiness in the amchi-patient relation below.

mined by free biomedical treatment. Through the competition with biomedicine, the amchi lost their monopoly over the largest segments of local health care.

As a consequence of the transformation of social relations in the villages, the amchi's authority and power shrank considerably, although their social status still remained high. It was nourished (at least on a theoretical level) by the altruistic attitude ascribed to the amchi. Because of their medical commitments, amchi kept on trying to cure any patient who would present themselves for treatment. Earlier, the patient's individual donations, consisting of small amounts of barley, butter, *chang* (beer) or *arak* (spirit), were given voluntarily, that is, in contrast to the fixed and seasonal communal labour, the quantity and frequency of these gifts were at one's own discretion.[11] Later, if the amchi asked for money, it took place in a face-to-face situation with the patient, and entailed the breakdown of the tradition of voluntarism and an amchi-patient relationship based upon trust. This discouraged the amchi from asking their patients to pay for treatment, and the villagers used it as an excuse not to pay.

Of course, this self-induced dissolution of reciprocity often caused a feeling of guilt among patients towards their amchi (cf. Kloos 2005). This guilt in itself is proof of a former reciprocal system of obligations accompanying the provision of medicines. But people did not take any steps to resolve this contradiction. The amchi, for their part, had to concentrate increasingly on making their daily living and consequently lost the free time which was previously used for their medical work. The quality and quantity of medicines decreased as the amchi were not able to collect medical plants in the mountains during summer anymore. Access to essential raw materials, and also ready-made medicines[12] that can be purchased in Indian cities, is much easier than it used to be in the past. Thus, amchi could choose between spending money on medicines or omitting certain ingredients and making low-quality medicines (Pordié 2002). In general, the amchi opted for the latter, and they did so for two reasons. Firstly, they prefer to spend their income on their own

[11] The obligations described above did not merely emerge from the gift, i.e. the medicine itself, but from the social equilibrium surrounding amchi medicine. They were located in the public community sphere in the way that each family had to contribute its part in working in the amchi's fields.

[12] Most medicines from Dharamsala are processed to pills which can be kept longer than the medicinal powders made by the village amchi in Spiti.

domestic consumption, rather than supporting village health care. Secondly, the summer months, when the roads to the Indian plains are open, are the essential time for work in the fields and earning a living. This time is too precious for an amchi to leave his place for two weeks or more.

The dearth of medicine and the invidious comparison with biomedicine has led to a decrease in patients' confidence in Tibetan medicine, and the amchi thus fall short of possibilities to gain knowledge and experience through practice. Under the pressure of modern needs and economic insecurity, amchi try, like everyone else, to find a job, whether in government service as a forest guard, contractor or officer, or in their own private enterprise. Also, the amchi's children who were supposed to learn in the family tradition, prefer to receive a school education first and get a job later. By going to school and/or gaining employment, large amounts of time became unavailable for medical training and work. Distinct working locations even result in amchi being absent from their villages for days and weeks during the summer (cf. Kuhn 1988). Today most amchi of Spiti valley have, besides their medical work, multiple income sources, including salaried jobs and also work as farmers, including cash crop cultivation. To sum up, being an amchi in Spiti became much less attractive and definitely a matter of economic concern. They can no longer make a secure living solely through medical practice.

In the Pin Valley, all the aforementioned concerns were exacerbated by the surplus of practitioners. Not only was free medicine from the biomedical health post available, but there was also the choice of several amchi. Thus, the villagers' dependency on one particular amchi evaporated. The 'new' amchi could never gain the social reputation that their older colleagues had enjoyed, because they were not descendants of an amchi lineage, did not have the medical knowledge or the medicines, and they were considered to have learnt amchi medicine only in pursuit of financial benefit.[13] A competition among the amchi emerged which was not made explicit. At the same time, people 'used' the breakdown of the former tradition of reciprocal exchange to their advantage, and the communities did not consider a replacement. This

[13] Kuhn (1988) recounts that in Ladakh, lineage amchi (*rgyud pa am chi*) also suspected non-lineage amchi of having egoistic motives for wanting to become Tibetan doctors.

affected all amchi, regardless of their capabilities, except for the few well-respected lineage amchi who had remained as the sole amchi in their villages.

In addition to the introduction of state-sponsored biomedicine, the surplus of practitioners that arose was a major factor in turning the amchi's formerly secure livelihood into its opposite. The respect of patients that the amchi hoped for, and the expected traditional economic security, were both dissolved by the glut of new amchi, and this in turn harmed the whole health care system of the villages. As the amchi system was based on the consensus of the community, the villagers partially withdrew their loyalty and, therefore, the legitimation of the amchi as well. The basis for making a medical living in Pin collapsed.

Obstacles on the Way to a Profession

The increased numbers of new amchi from Pin also had a wider impact on the situation of the amchi community in Spiti at large. In 1998, the decline of amchi medicine had led some Spiti practitioners to undertake steps aimed at the revitalisation of the system. Initiated by one of the amchi from Kaza, who had studied in Dharamsala, they together established an amchi association called the 'Spiti Board of Amchi Sangh'. They wanted to constitute a body that they knew would be necessary to interact with the government. Many amchi had hoped for financial involvement and support from the government and, to a lesser extent, from international and national organisations.[14] A further step in this fledgling professionalisation process was taken in 2002, with the establishment of the Amchi Sangh Clinic in Kaza, financed by the government of Himachal Pradesh. However, the activities of the Amchi Sangh were actually carried out by only two or three amchi. Also, from the start, the process was weakened by controversies among the amchi themselves, and hardly any engagement from many of them. To safeguard their families' livelihoods, many amchi preferred employment that generated cash. The accumulated difficulties in the inner organisation of the amchi association were somehow centred upon those new amchi from Pin. I observed that the Pin amchi are usually less commit-

[14] The amchi did not hope for international or Indian development support because until that time very limited activities of that kind had taken place in Spiti.

ted in spending time, money and effort on amchi work than the lineage amchi are. Some of their colleagues even suspected them of only being interested in the potential financial benefits of being a member of the Amchi Sangh, as well as in their work as an amchi. They would only join a meeting of the association if they expected economic support from the government. Sometimes they are accused of only pretending to be an amchi, and that their actual knowledge is so weak that they should not be allowed to posses the title.

The controversy about the new Pin amchi was not officially expressed, but had a strong effect, as one factor among many, upon the development of the amchi community. For example, the amchi of the upper Spiti villages decided to form their own association because they did not want to be involved with the Pin amchi. They were fearful of losing their reputation, because the Pin amchi's poor training was widely known. In response to the generally negative situation, together, all of the Pin amchi founded a separate association. Officially, both groups claimed their geographical remoteness and seclusion during winter as the main reason for requiring their own associations. But, in addition to this controversy,[15] all those involved were also hoping for more exclusive access to government funding. This incident put a visible end to the unity of the Spiti Board Amchi Sangh, although no one openly claims a total break of all ties. It is a clear expression of rising individualism (cf. Pordié 2003), which, when combined with economic concerns, strongly affected the progress of the modernisation of amchi medicine.

The precarious economic situation of Tibetan medicine in Spiti seems to be at odds with the individual economic progress of the population in general. Currently, villagers are able to save quite large amounts of money because while income is increasing, the possibilities of spending money are still restricted. Although money is definitely the primary medium of transaction, people are not yet ready to give the amchi fee-for-service. However, one of the Indian physicians posted in the area told me that patients are generally very willing to pay for health services. If someone has a severe disease that cannot be treated in Spiti, the medical officer sends him or her for treatment in the bigger cities on the Indian plains. Even for minor surgical operations, patients need to bear an expense of up to 20,000 Rupees. The doctor told me that

[15] It is even more complex because it includes personal quarrels and allegations.

many families have no difficulties in paying out this amount. Therefore, we find not only the ability to pay for health care, but also a willingness to invest in it, at least in certain medical situations.[16] Concerning financing the traditional medical system, occasional village contributions for the amchi to buy raw materials did take place. Some people in Spiti are also very aware of the precarious situation of their amchi and, if they are financially well off, will occasionally give them quite large sums of up to 1000 Rupees. But the total amount an amchi might receive from the villagers never meets the requirement of sufficient or long-lasting medical care.

Using a second set of examples, I will explore the situation in more depth here. For instance, a few years ago a Ladakhi amchi came to Tabo, a village in eastern Spiti where no local amchi lives. The Ladakhi opened a private clinic during the summer and provided medicine to patients in return for direct payment. Tabo is situated on Spiti's main road, and because amchi from Ladakh have quite a good reputation in general, many patients consulted the newly arrived practitioner. Although he charged more than 200 Rupees for a one-week course of medicine, patients kept seeking advice from him. A year later, he returned because the clinic had been such a success, even better than business in Ladakh. He raised his treatment fees to 400 Rupees, but since patients stayed away, he was forced to recognise that this was too much in the local perception of payments for such medicine. However, several wealthy Spiti residents do travel to the Indian plains regularly in order to seek amchi medicine. As some people consider the amchi from Manali and Dharamsala to be better trained than the ones in Spiti, they are even ready to spend up to 2000 Rupees for exclusive trips to visit those amchi.

These examples demonstrate that, not only are Spiti people able to pay considerable amounts of money for single treatments, and that they still value Tibetan medicine, but also that they draw a distinction between 'their' village amchi and 'outside' amchi (cf. Kloos 2005). 'Outside' in this case means only that the amchi is not from their own village. As soon as people leave their villages to seek treatment in

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[16] See Yoder (1989) for a discussion of the "'willing and able to pay' rationale" concerning user fees at biomedical institutions. In contrast to that study, utilisation of health services depends in Spiti more on the seasonal and infrastructural conditions to reach the intended institution than on the ability to pay for it.

Spiti's main town of Kaza, or in Kinnaur and Kullu, they are fully prepared to pay for medicine.

I will illustrate a further crucial point by discussing two amchi from Kaza. These two are the only amchi in Spiti who were fully trained in Dharamshala, though in two different institutions. Both of them have many years of experience in the environment of 'modern' Tibetan medicine which exists among the exiled Tibetans. The Tibetan medical clinics in Dharamsala, such as the Men-Tsee-Khang and Dr Dolma Clinic, are professionalised especially in terms of their production of medicine and their orientation towards a global health market. In Dharamsala, the two Kaza amchi became accustomed not only to Indian and Tibetan patients paying money for medicine, but also to patients from all over the world ordering large quantities of medicine by mail and paying for it in foreign currencies. One of these amchi was the driving force behind the opening of the Amchi Sangh Clinic in Spiti, while the other one wants to open a private clinic. Both of them bring back ready-made medicine from Dharamsala, and prescribe them for their own patients by taking certain amounts of money.[17] Nevertheless, in general, the remuneration which they receive from their patients is often less than the cost of the purchased medicine. The facts become more concrete when we reflect that people sometimes refer to the Amchi Sangh Clinic in Kaza as a "shop" or *dukān* in Hindi.[18] What the amchi at this clinic is doing is considered as 'selling medicine'. The amchi is not being paid for his work, but it is only the medicine that is paid for. In this way, the amchi cannot be suspected of taking money for himself and, at the same time, medicines become commodities (cf. Kopytoff 1986). Many amchi told me that they feel comfortable extending this 'model' of a private or public clinic to their villages. Still, they did not agree to be paid for their actual time-consuming work. Here the orthodox view still claims the value of the amchi's work as that which cannot be paid back, but only voluntarily returned. By selling medicine,

[17] The medical practitioner at the Amchi Sangh Clinic writes down the medicine on a patient record pad and adds the amount of money to be given for the full course, considering the actual cost of the medicine as well as the patient's ability to pay. The amount for a one week course never exceeds 100 Rupees, and poor people do not have to pay. The patient will give the money without being asked and usually the whole process takes place without mentioning anything related to the money transfer.

[18] This matches with a tendency observed in Ladakh that the closer one gets to the centres the more monetised medical institutions become (Pordié 2002).

village amchi would have at least a little income to buy medicines, without being accused for losing their altruistic attitude and therefore their traditional legitimacy.

CONCLUSION

Contrary to the past, when learning the medical profession as an amchi meant having an economically secure living, today's amchi have now come to take other realities into account. Firstly, amchi need to be financially remunerated. A young amchi put it frankly in these terms: "If someone is working he should have some benefit. Today everybody is working for benefit. If there is no benefit, why should I work as an amchi?" With this statement he goes beyond what most of his older colleagues would say or feel comfortable saying. But he gives a clear expression of the practical reality. If in the near future no income arises from the amchi's work, then qualitative health care will not be provided and Tibetan medicine in Spiti will have no future. Secondly, at the present time, a permanent payment or salary for the amchi is not forthcoming from local communities. Consequently, external funding becomes a possible solution, or the one which could bring about the solution to all the problems. The government, and for a few years now also foreigners, are possible external sources of income. Because foreign funding is less accessible, the amchi put their efforts into the Amchi Sangh Clinic, thereby hoping to gain financial support from the government. The developments of the last two years seem to give this approach a good chance, because the state government of Himachal Pradesh is willing to give fundamental funding to 'traditional medicine' in remote and tribal areas. Nevertheless, the lack of education among the amchi remains a large barrier to success, as none of the amchi is able to communicate adequately with government offices.

The initial introduction of money as a payment for medicine, as well as the formal organisation of their profession, and the establishment of a clinic, are the first outcomes of the amchi's ambitions to professionalise their work. They have been organising this process according to state requirements, and also in line with inspirations from the exemplary model of the Tibetan clinics in Dharamsala, since the Spiti amchi have tended to imitate them. But medical practitioners at centres of Tibetan settlements in India, or those in Ladakh, Nepal or Tibet can

look back to a history of development of several decades, if not more. Without the involvement of international NGOs—as has occurred in Ladakh, Nepal and Dharamsala—or large-scale, state-directed modernisation—as was undertaken in the Tibetan Autonomous Region in China—the Spiti amchi are mainly left to their own devices. Lack of education and financial assistance are the self-perceived obstacles on the way to a survival of the traditional medical system. Among the amchi, money is the synonym for the ultimate solution to their daily problems, which runs complementary to representations prevailing in local communities at large.

Not all amchi in Spiti are actively involved in attempts to professionalise their work, a revival which they perceive as their fight against the windmills of modernity. The problem invades from 'outside' in the form of state administration and biomedical hegemony, but also comes from inside their own society in the form of changed economic conditions that constituted the withdrawal of support without substitution. Nevertheless, the main part of the current process is a modification of the status of the actual medicines themselves. Today, most village amchi give medicine to the patients without receiving something in return from the community, neither labour nor money. The reciprocal exchange of gifts, with its norms and obligations, has dissolved in regard to medicine in the local, village context. If patients go to visit an amchi outside of their own village, they pay for the received medicine. Therefore, money increasingly assumes the position of the counterpart value (Kopytoff 1986) for medicine. The sphere of medicines becomes monetised. In contrast, medical work itself remains in the gift and counter-gift sphere, because in the understanding of the villagers it cannot be paid for. The amchi and their communities see altruism as a fundamental element of the amchi-tradition. A fully commercialised amchi medicine, with fixed prices for diagnos and treatment, one that would also cover the costs of the daily amchi work, is not an option for the people of Spiti. Corresponding with Mauss, the contemporary change to the monetisation of amchi medicine is an example for the complex social rootedness of exchange. But in contrast to Mauss' argument that the altruistic character of the gift is only a superficial expression which masks personal interests (2002 [1954]), the amchi's altruistic attitude is the basis of his work, and one that, for instance, guarantees the effectiveness of his medicine. This is why the amchi's work as a sphere of exchange resists the introduction of money (cf. Bloch and Parry 1989).

As part of the rapid development process in Spiti, villagers quickly adopted the individual attitudes and possibilities of the money economy. Earning a living has always been largely restricted to the summer months, and today people use this period to gain additional income. Until now, the amchi and the villagers were not able to independently change the traditional health care system into one that functions in a modern context. Therefore, in the local view, making a medical living is only possible with external funding, something which removes the socio-ethical contradiction from the amchi-patient relation. A salaried, government position for an amchi is seen as the best option. The amchi imagine this as a full-time job which corresponds to the availability of a large range of government positions. This would certainly constitute a next step towards the professionalisation of amchi medicine. One aspect of a possible government amchi position would be supplying medicines to patients for free. The amchi prefer this option, as they hesitate to include money in their work. But free drugs have in general considerably less value in patients' perception. It is a daily experience in Spiti that patients come from the hospital and do not use the free prescription medicines, or throw them away. Additionally, free drugs in regard to amchi medicine would bring an end to the counter-giving in the amchi-patient relation. While today's practice in Kaza of giving money in return for medicine still includes a reciprocal exchange, the possible solution of establishing government amchi positions would even remove this element from the amchi-patient relation. This might solve the actual contradictions and psychological and economic problems outlined in this research, but it would also turn the amchi's work into a service, as just one among a range of other government services available to the population of Spiti.

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THE LAND OF MILK AND BARLEY: MEDICINAL PLANTS, STAPLE FOODS, AND DISCOURSES OF SUBJECTIVITY IN RGYAL THANG

Denise M. Glover

Introduction

Ethnobiological research conducted throughout much of the world has shown that traditional environmental knowledge among indigenous groups is often highly specialised, and frequently entails extensive knowledge of medicinal uses of local flora and fauna (Berlin 1999; Hunn 2002; Moerman 1998; Voeks 1995). I began research with Tibetans in Rgyal thang in 1999 hoping to find just such extensive medicinal plant knowledge. What I discovered, however, was an interesting dynamic between a pervasive local repository of information on medicinal plants, average working household knowledge of a few medicinal plant species, and a discourse of plant knowledge loss that I argue is intricately connected to other discourses of subjectivity among Rgyal thang Tibetans.[1] This is accompanied at the same time by a popular emphasis on milk and barley products as having medicinal properties that I argue has critical symbolic significance for local Tibetan identity.

In this paper I have three main objectives. The first is to briefly discuss my findings on household knowledge of medicinal plants in Rgyal thang. Although the discourse of common householders centers on the loss of knowledge of how to use local plants medicinally, they do not completely lack knowledge of remedies altogether. It is important to keep the latter in mind as a counterbalance to local proclamations of diminished knowledge not because it is somehow more objectively true than the discourse of knowledge loss, but because it provides a context

[1] Throughout this article I use 'household knowledge' in contrast to the knowledge of specialists in the area, such as doctors of institutional Tibetan medicine (who are trained in formal institutions and practice at local hospitals and clinics or privately) as well as village doctors (who are trained in lineage traditions and practise privately).

within which to understand local discourse more clearly. My second objective is to analyse the discourse of lost medicinal plant knowledge (knowledge loss) in relation to discourses of commodification (of medicine) and ethnic identity in the Rgyal thang area. In the domain of self-healing remedies, the commodification of medicine has displaced local knowledge in the subjective experiences of Rgyal thang Tibetans. In terms of ethnic identity, since the modern subject in this area of China is in part defined by ethnicity and since 'traditional' medicine (and by implication knowledge of medicinal plants) is linked to ethnicity throughout the nation, Rgyal thang Tibetans gauge their own medicinal plant knowledge (or lack thereof) in terms of their ethnic identity. Finally, I turn to an analysis of the symbolic importance of milk and barley as integrally connected to the discourses of subjectivity with which Rgyal thang Tibetans are engaged. In essence, the reported effectiveness of milk and barley, as remedies for general ailments and to maintain good health, combined with the symbolic power of these products, creates a dominant discourse in relation to other discourses of subjectivity. An analysis of this dominant discourse, then, becomes central in understanding the subjective world of Rgyal thang Tibetans. I employ James Scott's idea of 'everyday forms of resistance' (Scott 1985, 1990) to discuss the agency of Rgyal thang Tibetans in creating their own sense of worth and identity given the current socio-economic conditions within which they are living.

Research Setting and Methodology

Rgyal thang is located in the southernmost reaches of Khams. Of the six *sgang* 'ridges/highlands' of Smad Mdo Khams, Rgyal thang is located in Spom 'bor sgang and roughly corresponds to present-day Shangrila County in Diqing Tibetan Autonomous Prefecture (Diqing Zangzu Zizhizhou), northwest Yunnan Province.[2] Essentially there are two Rgyal thangs: Rgyal thang_1, which refers to the greater cultural (and previous administrative) area, and Rgyal thang_2, which refers to the core town of the greater cultural area. The research presented in this

[2] Zhongdian County was officially renamed Shangrila County (Xianggelila Xian) in May 2002. I use the Chinese name of Diqing (Tib. Bde chen) Prefecture to highlight its creation under the modern Chinese state.

paper was conducted in 2001 and 2002 in central/ 'navel' Rgyal thang (Rgyal $thang_2$), in the town known in Chinese as Zhongdian, and in surrounding villages.[3]

While Rgyal thang is part of the Tibetan Autonomous Prefecture of Diqing, it is also a multiethnic area. According to the 2000 Census of the PRC, the Tibetan population in Zhongdian County was 40%, followed by Han at 22%, and Naxi at 18%. Although not a majority, Tibetans constitute the largest 'ethnic group' or 'nationality' (Chin. *minzu*) in the county. It is important to keep in mind the multiethnic (and multilingual) makeup of Rgyal thang, particularly in a province that boasts of having a 'mosaic' of ethnic groups. 'Ethnic consciousness' may be at an all-time high in contemporary China and this undoubtedly has an effect on the subjective experiences of Rgyal thang Tibetans. All interviews upon which this paper is based were conducted with people that identified themselves as Tibetans.

Most Rgyal thang Tibetans are agriculturalists having stocks of yak, *mdzo* or cattle,[4] pigs, chicken, and sometimes sheep. Often, livestock is taken to higher elevations for grazing during the summer months, although—as is characteristic of agro-pastoral communities (*sa ma 'brog*)—a strongly pronounced transhumance does not appear to be practised. Barley and wheat are the main crops grown, followed by potatoes and mustard seeds.[5] No mechanised equipment for planting or harvesting is used and most farm tools are wooden. In Zhongdian town Tibetans have various occupations, from government employees to

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[3] The scholar/abbot in exile Lha mkhar Yongs 'dzin dge bshes Bstan pa rgyal mtshan (alias Dge bshes Gyang ra) wrote in 1985 that Rgyal thang consists of five *rdzong* (an administrative unit where the district magistrate was headquartered; a county, Chin. xian, can correspond roughly to a former *rdzong*): Rgyal thang yul lte ba (central, literally 'navel' Rgyal thang), Gter ma rong (Chin. Dongwang), Yang thang (Chin. Xiao Zhongdian), *'Jang* (the area north of Shigu, near the first major bend in the Yangtze), and Rong pa (present-day Nying shar area). Dge bshes Gyang ra's explanation of a greater Rgyal thang area centred on a core, navel town of Rgyal thang (what I refer to as Zhongdian) is one that is corroborated by many Tibetans in the area today. I thank Wang Xiaosong of the Diqing Institute of Tibetan Studies in Zhongdian for helping me make sense of the relation between textual place names and those on current Chinese maps.

[4] Many Rgyal thang Tibetans refer to their animals as yak (*g.yag*) although I have been told by others (mostly from outside the Rgyal thang area) that there are no 'true' yak in Rgyal thang at all.

[5] I do not have statistics on crops grown. The assessment given here of the importance of potato and mustard seed crops for the local economy is based purely on my own observations.

shopkeepers. In addition, Tibetans from outlying villages often come to Zhongdian to sell their wares: wild mushrooms, caterpillar fungus (*Cordyceps sinensis*), apples and other seasonal fruits, yogurt, and cheese.

The environment in Rgyal thang and the surrounding area is an interesting mix of temperate to alpine (boreal) vegetation. Valley floors between 2,000 and 2,500 m are often dotted with cacti, palm trees, and eucalyptus, while alpine areas of 3,500 m and more host rhododendrons, gentians, and the prized snow lotus (*Saussurea medusa*). Both Rgyal thang and nearby Deqin County have a high density of biodiversity. Ideal growing environments make possible a wide range of vegetation types and many of the medicinal herbs used in both Tibetan and Chinese medicines come from these areas.

Given Rgyal thang's natural endowment in medicinal plants, the extended human habitation of the area for several millennia,[6] and a history of trade in medicinal products (plants, animals and minerals), I began my study anticipating that the utilisation of these resources by local inhabitants might be substantial. While most of my time in Rgyal thang was spent with several doctors of Tibetan medicine, who are experts in medicinal plant knowledge,[7] part of my research included investigating variations in local knowledge of medicinal plants—from institutionally-trained doctors to privately practising village doctors to lay persons. What I found is that knowledge does appear to vary quite significantly among these different groups.

This paper discusses my findings among the lay population in the town of Zhongdian and five surrounding villages: Tsomgolu, Chu snying, Bongchating, Tsoli, and Yang thang.[8] In 2001 and 2002, 36 interviews with lay people were conducted, lasting between one and two

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[6] While troops from the Tibetan Empire apparently settled the area in the seventh century, human habitation in Rgyal thang has been dated through the archaeological record to at least five thousand years ago. See Diqing Zangzu shehui shi ("History of Tibetan Society in Diqing") as quoted in Marshall and Cooke (1997).

[7] Research with these doctors provided the basis for my dissertation fieldwork. See Glover 2005.

[8] It should be noted that I could not obtain reliable spellings for three of these five villages (Tsomgolu, Bongchating, and Tsoli) and have therefore relied on approximate transliterations of local pronunciations. Most of the population in the Rgyal thang area is not literate in Tibetan.

hours each.[9] Interviews began by inquiring about the most common ailments experienced in the household and then continued by investigating methods of treatment for these ailments. Home remedies were recorded, including information on how ingredients were obtained (self-gathered, purchased, received as a gift), preparation, dosage, and amount used per year.[10] If plant material was available—either in the house or within the surrounding area—I requested it to be shown to me. If home remedies did not exist, I inquired as to where treatment was sought (from hospital, clinic, monastery, or other) and which type of medicine, if any, was taken (Tibetan, Chinese, or Western). Depending on how earlier questions were answered, I also inquired about how and from whom the interviewee learned these remedies and if he/she was currently teaching them to anyone.

FINDINGS ON HOUSEHOLD KNOWLEDGE

The most common ailments that interviewees mentioned were colds, fever, headache, diarrhoea, stomachache, toothache, cough, and rheumatism/arthritis.[11] On average, men tended to articulate more working knowledge of medicinal plants than did women, although their knowledge was usually limited to one or two plants.[12] Some of the plant remedies seem to be village-specific. For example, in the village of

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[9] Interviewees were chosen for representative sampling of age and gender. Interviewees ranged in age from their mid-twenties to early seventies, with an average age of 50; 56% of the interviewees were men while 44% were women. I chose not to control for occupation (besides the requirement of not being a 'professional doctor'). The majority of interviewees were farmers; variations from this main occupation included a government worker, a banker, a driver, a schoolteacher, and a car-repairman. The majority of interviews (28 of 36) were conducted in Rgyal thang Tibetan dialect; seven interviews were conducted in Chinese (Mandarin) and one was conducted in English.

[10] Dosage and yearly consumption were often very difficult to discern, as people usually used vague measurements (such as, 'a handful', a 'sack-full' etc.) and relied little on exact measurements.

[11] There is an extensive literature on the difficulties of translating illness categories; the names given here are approximations.

[12] And yet, interestingly, the most knowledgeable person I interviewed was a woman aged 67 living in the old part of Zhongdian town, Rdo mkhar rdzong. I will return to a brief discussion of this woman below.

Bongchating, about 30 km west of Zhongdian town, people mentioned the use of a local plant, called 'Tonghong', for toothache.[13] Not only was this plant not mentioned in other villages but also doctors of Tibetan medicine at the Tibetan Hospital in Zhongdian had never heard of it. Villagers told me that a Naxi family, the only non-Tibetan family in the village, taught villagers about the plant about a generation ago. Common remedies of self-treatment that spanned from village to village and into Zhongdian town included the use of particular plants, such as "Dpa' bo ser po" (*Veratrilla sp.*) and "Myong rtsi spras" (*Coptis sp.*). These plants grow locally and most interviewees collect them themselves once a year. Both plants are used for headaches and colds, and in all cases the roots of the plants are utilised. Despite the popular usage of these two plants within the five villages and Zhongdian town, however, the most commonly mentioned ingredients for self-healing remedies were milk and barley products. It gradually became clear to me during the course of my interviewing that the presumption I had begun with (high probability of extensive household medicinal plant knowledge) was only a starting point. What is much more intriguing than the fact that there does not appear to be high utilisation of local plants medicinally (at the level of self-treatment by householders) is how Rgyal thang Tibetans talked about their own knowledge and their subjective experiences. I was continually struck by the recurrent themes of knowledge loss, commodification of medicine, and the integrity of milk and barley.

It is important to state that in this paper my assessment of lay people's knowledge is based exclusively on what they were willing to convey to me, not on observed practices. While a more extensive research project could involve an in-depth assessment of practice, the present work is interested in how local experiences of subjectivity become articulated within the framework of medicinal plant knowledge (a frame with which I began my study), how articulations are intertwined, and how an understanding of these interconnected discourses can be applied to an analysis of the importance of milk and barley for Rgyal thang Tibetans. In short, the present work explores what can be gleaned about local conceptualisations of subjective experience through what Rgyal thang Tibetans communicate about themselves.

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[13] I have not been able to ascertain the identity of Tonghong although the name itself sounds Chinese.

LOST KNOWLEDGE

A common theme that I encountered in interviews with people of all ages is the expression of knowledge loss in the domain of medicinal uses of plants. "We used to know [how to use plants medicinally]", one man commented. "Older generations knew about this", corroborated another. "We don't know any of this stuff anymore!" exclaimed a woman in Yang thang village. Often people would expressively flip their hands over quickly in a gesture of not having anything and would shake their heads. Sometimes people seemed to lament the fact that they did not have any 'useful' information for the visiting anthropologist (i.e. me). And yet, on average, most common householders knew of a few remedies to share.[14] Of specific interest to me is the pervasive belief among most interviewees that a particular community body would be more knowledgeable than their own; and such a 'knowledgeable' cohort was always said to have existed a generation or two before. Thus, as was stated by a 36 year old man, "We're too young, we don't know much [about plants and healing]. Older folks do know". "You'll have to ask someone older about this", added another man in his thirties. And yet, when I interviewed 'older people' (aged 55 and up) I found that they were not necessarily more knowledgeable on the whole than middle-aged or younger folks.[15] Older people certainly commented that they themselves did not know as much as their parents used to. In other words, it became obvious that a consistent discourse of knowl-

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[14] Due to space constraints, in this paper I am not able to explore fully my own positionality as an ethnographer, although it is certainly a legitimate aspect of the research to consider. In addition, it is possible that there may be certain family remedies or recipes that were not deemed appropriate to share with me. Again I would herein reiterate that my objective in this paper is not to give an 'accurate assessment' of medicinal plant use but rather to explore the discourse surrounding popular plant knowledge as it was expressed to me.

[15] However, the interviewee with the most extensive knowledge was a 67 year old woman living in the old part of Zhongdian town, Rdo mkhar rdzong. She readily mentioned 15 different medicinal plants in the area that she utilises, some of which she only knew by their Chinese names. She explained to me that she had troubles with rheumatism/arthritis as a child, and that her father taught himself (from books) how to use local medicinal plants and then taught her. (It was not clear if there was a direct causal relationship between her childhood sickness and her father's interest in medicinal plants). She regretted that neither her children nor grandchildren were interested in learning from her and added that they would rather just go to a hospital or clinic for treatment.

edge loss is presently shared across generations, regardless of age, and that the existence of a more complete knowledge of medicinal plants is projected into a distant past altogether. In the following, I will explore what this local sentiment of loss among present generations of Rgyal thang Tibetans implies with regard to larger socio-economic issues.

COMMODIFICATION OF MEDICINE IN RGYAL THANG

Usually, the comments that followed statements of knowledge loss referenced the increased presence of professional health-care workers (including doctors of Tibetan medicine) and the availability of prepared medicines—whether Tibetan, Chinese, or Western medicines. People explained to me that 20 to 30 years ago medicine was difficult to obtain, even Tibetan medicine, which mostly came from Lhasa (this might in fact give us a clue as to why it was important to hold such knowledge, i.e. a matter of survival). Now, people commented, prepared medicines are easy to get. You can buy them at hospitals, pharmacies, and apothecaries in Zhongdian. Some of these medicines are locally produced, some are from Lhasa, and some (particularly Chinese and Western medicines) come from Kunming or other parts of China.[16] Most interviewees said that although medicines are more available now, they are also more expensive. As one 41 year old woman from Bongchating village commented, "When I was younger medicine was hard to get but cheap. Now it's easy to get but expensive".[17]

Additionally, interviewees commented that doctors are more prevalent now, especially in Zhongdian. While the County Hospital was founded in 1952[18] and state-run health clinics proliferated in the 1960s,

[16] Ironically, much of the Tibetan medicine that Rgyal thang Tibetans purchase contains plants gathered in Deqin County and Rgyal thang. The Tibetan Hospital in Zhongdian manufactures and sells its own medicines (which consist in large part of locally gathered plants) as does the Tibetan Medicine Factory in Zhongdian (which used to be part of the Tibetan Hospital but is currently owned by a businessman from Kunming).

[17] Only one interviewee mentioned that medicines are actually cheaper now than they were before. However, this man had an above-average income as a private driver; his remarks undoubtedly reflect his economic standing and are not representative of the sentiment of most Rgyal thang farmers.

[18] The County Hospital (Zhongdian Xian Weisheng Yuan) officially became the County People's Hospital (Zhongdian Xian Renmin Yiyuan) in 1956.

it is difficult to know how much these institutions were accessed by local Tibetans at the time. According to my interviews they were fairly underutilised, at least for common ailments.[19] Tibetan medicine was not institutionalised in the area until 1979, when a Tibetan medicine clinic was established at the Prefectural People's Hospital. Later, in 1987, a separate Tibetan Medicine Hospital was established, where Tibetan doctors practise Tibetan medicine.[20] Some villages in the area may have had resident village doctors, but in only one of the villages under consideration had there been such a practitioner in the past 40 years.[21] One woman noted the increased pervasiveness of doctors and the convenience this brings: "Oh it's much easier to see a doctor now than having to treat yourself". Furthermore, the combination of greater availability of both medicines and doctors has generally created improved health care conditions, people noted. One woman from Bongchating village stated:

> When I was younger, we could only get medicine from Lhasa. Now we can go to the hospital in Zhongdian if we get very sick. Previously if you got really sick you would just die![22]

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[19] It should be noted that the local monastery in Zhongdian, Sum rtsen gling, does not appear to have a significant history of providing medicines or medical services to the local community.

[20] My conjecture is that Rgyal thang Tibetans first became exposed to professional doctors through the Tibetan clinic at the Prefectural Hospital and later the Tibetan Hospital. Frequently people told me how incredibly busy the doctors were the first few years after the Tibetan clinic opened—patients would wait in line for hours to see a Tibetan doctor. One of the two doctors involved with establishing the clinic in fact told me that they could not make enough medicine to keep up with the demand for the first two years and were often overwhelmed, having to turn patients away. I suspect that local Tibetans were interested in the Tibetan medicine clinic in part because the doctors were Tibetan themselves.

[21] This village doctor, who was quite renowned throughout the greater Rgyal thang area, had died in 1955. His son, who was ten at the time of his father's death, no longer lives in the village but instead now resides at Sum tsen gling Monastery (where his own son is a monk) on the north end of Zhongdian town. The famous village doctor's son did train with his father before his death but he once explained to me that he was unfortunately not able to learn very much from his father since he was so young at the time. Nonetheless, he still treats patients at the monastery and apparently specialises in the treatment of stomach ailments.

[22] And yet this health care is becoming increasingly difficult to access for those without money. Although doctors' visits at local hospitals are free, patients have to pay out of pocket for most medicines. There are a number of independent practitioners in Zhongdian who charge rather reasonable rates —in many cases they even treat patients for free. Most of these independent practices operate less as commodity-based businesses and more as 'charities', accepting whatever bit of money or other offerings (usually food) patients give, rather than having set rates for treatment.

But the availability and convenience of commodified medicine has its costs. In interviews, discussions about the availability of prepared medicines and professional services were directly connected to the discourse of plant knowledge loss, in a nearly causal relationship. One man in Tsomgolu village stated:

> We used to know [how to use plants medicinally], but now it's so convenient to just get what you need in Zhongdian that we don't know how to use these plants anymore.

Another man in Yang thang village supported this view in nearly an identical manner, "Most people don't know how to use plants anymore, they just go to the hospital". One man in Yang thang village commented that he buys Myong rtsi spras (*Coptis sp.*), one of the few plants that is mentioned as a remedy in this area, at the County Hospital. He explained that even though he can dig the plant himself, he does not know the proper medicinal preparation and therefore the plant never has an effect when he tries to apply it. Greater availability of medicines and doctors has created a situation where knowledge of self-healing through use of medicinal plants is fading, people asserted. In becoming more reliant on health care professionals, the institutions in which such professionals operate, and commodities of medicines that can be purchased, Rgyal thang Tibetans feel that part of their cultural knowledge base is dwindling.[23]

Medicine and Ethnic Identity

While the use of medicine in Rgyal thang is pluralistic, with consumption of Tibetan, Chinese, and Western medicines, it is also closely connected to ethnic identity. Tibetan medicine, throughout China, is ethnically marked in Chinese as *zang yi* or *zang yao*, while Rgyal thang Tibetans mostly refer to it by using the Tibetan term *bod sman* (Tibetan medicine) rather than Chinese *zang yi*.[24] Chinese medicine

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[23] This assessment is in part supported by research conducted in the field of ethnobiology over the past decade or more that has shown that increasing commodification and urbanisation throughout the world lead to knowledge loss of local medicines. For a recent example, see Zent 1999.

[24] The distinction between Chinese *yi* and *yao* is essentially that *yi* generally refers to the practice of medicine while *yao* refers to the material of medicine (pharmaceuticals, medicinals).

is, instead, the unmarked, non-ethnicised category of *zhong yi/yao*, medicine of the 'Middle Country', or, more contemporarily, the nation.[25] In the past decade or more, 'traditional,' institutional Tibetan medicine, as practised at the Tibetan Hospital in Zhongdian, has been touted as one of China's great medical treasures, although its status in relation to Chinese medicine is somewhat ambiguous. Often Tibetan medicine gets lumped in with other medical systems of China's 'ethnic minorities'. At the 1999 World Horticultural Exposition in Kunming, for example, an exhibit of 'ethnic medicines and drugs' presented a variety of 'non-Chinese' medical traditions as examples of the wondrous storehouse of resources of the nation, both in natural materials and knowledge systems. Similarly, a publication titled *Zhongguo shaoshu minzu quantong yiyao daxi* (*Collection of Traditional Minority Medicines of China*) from the year 2000 makes explicit the fact that the Tibetan medical system is one of several great traditions of the Chinese nation.[26]

Expressions of 'Tibetan culture' are now not only accepted but also encouraged in Yunnan—within limits.[27] While folk healing remedies in Rgyal thang are somewhat kindred to healing remedies of institutional Tibetan medicine, and although they are not necessarily equally noticed or acknowledged by the state, they are practices of a Tibetan population whose members seem keenly aware of their ethnicity and who identify

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[25] It is significant that even when speaking Tibetan many Rgyal thang Tibetans use the Chinese term *zhong yi/yao* (national medicine) and *xi yi/yao* (Western medicine) rather than the Tibetan *rgya sman* (Chinese medicine) and *nub phyogs pa'i sman* (or sometimes *phyi gling pa'i sman*), respectively for 'Western medicine'.

[26] For further discussion of this exhibit as it pertains to ethnic discourse in the PRC, see Glover 2005. See Janes (1995) for a brief discussion of classifying Tibetan medicine under the rubric of 'Chinese traditional medicines' in documents issued by the central government. Also see Adams (2001) for a discussion of how practices considered 'scientific' (read: apolitical) in Tibetan medicine in the TAR are acceptable while those considered 'religious' (i.e. political) are not. Although religious and political expression in Yunnan does not seem as aggressively repressed as in the TAR, Adams' point is worth considering for any national discourse on Tibetan medicine.

[27] Specifically the tourist industry is an openly encouraged venue for expression of ethnic identity throughout China. In May 2002 Zhongdian County was renamed Shangrila County after the mythical paradise depicted in James Hilton's 1933 novel *Lost Horizon*. Along with this renaming, the county has financed re-surfacing of most buildings in Zhongdian with 'Tibetan' style painting, mandated Tibetan language on all business signs (in addition to Chinese and sometimes English), and encouraged county employees to dress in 'traditional' Tibetan *phyu pa*. See Kolås (2004) for an interesting discussion of the role of tourism and ethnic identity in the place creation in Rgyal thang.

with a specifically Tibetan worldview. The connection between folk healing practices among Rgyal thang Tibetans and institutionalised Tibetan medicine is in some ways strengthened by common ethnicity. Because they are Tibetan, and the 'great tradition' of Tibetan medicine is officially sanctioned as a legitimate medical system within the PRC (and a treasure of the 'Motherland' to boot), Rgyal thang Tibetans may feel a certain amount of expectation towards their own basis of cultural knowledge. This may be reflecting in the discourse of loss: we don't know this now, but we must have known it before since this is part of a traditional Tibetan knowledge system.

Discussions of ethnicity in one form or another arose in nearly all interviews, in part, I argue, because the discourse on 'traditional' medicine and medicinal plants is effectively linked to ethnic discourse in the contemporary PRC. This linkage plays out on the level of consumption, where all Rgyal thang Tibetans interviewed reportedly consumed purchased Tibetan medicine and consulted Tibetan medical services, whether institutional or private. Although interviewees said that they sometimes use non-Tibetan medicine (either Chinese or Western) for certain ailments, an essential component in their consumption of purchased medicines and services remains Tibetan medicine. So, being a Tibetan patient in Rgyal thang means foremost using Tibetan medicine. On the level of household medicinal plant remedies, however, knowledge thereof becomes quantified in relation to other ethnic groups. One man in Yang thang village highlighted what he saw as an important difference in ethnic knowledge basis:

> Han, Yi, and Naxi know how to use plants and harvest them in the high mountains. Most local Tibetans don't know much. There was one Tibetan guy about 16 years ago who knew about plants but he didn't teach anyone and now he's dead.

Two other interviewees mentioned that village remedies came from non-Tibetan families: one Naxi, one Lisu. On the level of assessing their own knowledge of medicinal plants, Rgyal thang Tibetans often compare themselves with other ethnic groups and find their own knowledge lacking. It is perhaps here that the 'common bond' of ethnicity between non-professional, householders and professionals of Tibetan medicine in Rgyal thang weakens. In fact, as discussed earlier, the professionalisation and commercialisation of Tibetan medicine is often pointed out as a potential cause for the decrease of medicinal plant

knowledge among householders. In this way, the divide between the knowledge possessed by professionals of Tibetan medicine and that of 'non-professionals' in some ways lends disjuncture to the 'common bond' of ethnicity. Yet this bond can be reestablished through the daily appreciation of and reverence for other markers of Tibetan identity: milk and barley.

Milk and Barley: Revival and Resistance

If Rgyal thang Tibetans feel that they have become more dependent on professional, commodified medicine, which—at least in their subjective experience—in turn has caused them to lose knowledge of medicinal plants and home remedies utilising these plants, what can be done to (re)claim a sense of control over both their own health care and valuable 'traditional' knowledge? One possibility is to seek empowerment in a realm in which they do have control. James Scott (1985) has termed this 'everyday forms of resistance', stressing that such resistance usually involves no collective action and is often not openly challenging the basic structure of domination; these forms are instead 'hidden transcripts' (Scott 1990) of noncompliance. Since most common Tibetan householders in Rgyal thang are farmers, milk products and barley are their staple foods. The production and consumption of these goods seem little threatened by current economic trends in the county. While not at all antithetical to canonical Tibetan medicine, which stresses the importance of proper diet as one of the foundations of good health, Rgyal thang discourses of health and healing seem particularly rooted in local Tibetan economic and cultural life.

As mentioned previously, answers to my queries about home remedies were dominated by responses that included both milk and barley products. 'Whey' (*phyur khu*), 'yogurt' (*zho*), and/or 'cheese' (*phyur ba*) were mentioned in over half of the interviews, usually to treat headaches, stomach problems and colds. A woman in her late 60s gave one of the most cogent explanations I encountered about the benefits of milk products. While our conversation focused mainly on the 15 different plants that she uses medicinally, she prefaced the interview by saying that in general her family stays quite healthy. When I asked why, she responded with a well-reasoned argument:

> We eat lots of cheese, yogurt, and milk. These products come from animals that graze in the high meadows and eat herbs with medicinal properties. Since we drink the milk of these animals, we benefit from their diet and in turn receive doses of medicine ourselves.

This was not the first time that I had heard this explanation, although it was one of the most articulate accounts. While milk is obtained through the reliance on livestock, barley is the product of human labour and depends on soil, rain, and sun. Barley, in the form of *rtsam pa*, was mentioned across villages and in Zhongdian town as a remedy for similar ailments—headache, cold, and sometimes stomach problems. Often barley is mixed with other foodstuffs, such as garlic, chili or cheese that are added for medicinal properties as well as taste. One man commented that if one gets a cold, it is important to eat well—and such a diet includes lots of barley consumption. As a prophylactic, barley has many benefits, particularly for potency. Barley gives strength, people noted; it maintains vigour and can revive a weakened body. Although some interviewees mentioned other foodstuff as remedies, such as chicken, eggs, turnips, and pig's fat, milk products and barley were the two classes of food most readily mentioned as prophylactics and healing remedies by the majority of interviewees.[28]

In essence, milk and barley products become virtual medicines outside the realm of, and in reaction to, commodified, prepared medicines (from Chinese, Western, and Tibetan medical traditions), and in a wider sense, in reaction to the non-Tibetan world and the nationalist absorption through the state. As previously mentioned, Rgyal thang Tibetans on average utilise institutionalised Tibetan medicine above all other, at least in part because it is Tibetan. But even doctors of traditional Tibetan medicine have gained some control over the health and healing of common householders in Rgyal thang within the past several decades. Having become somewhat reliant on professionalised medicine, and feeling that they are no longer able to effectively utilise many local plants for healing, Rgyal thang Tibetans nonetheless maintain some sense of control over their own health and healing by explicitly appreciating and acknowledging the very basics of their dietary exis-

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[28] Similar to my findings on the use of most medicinal plants, foods—other than milk and barley—used as medicines were village-specific. Thus the use of pig's fat as a topical rub for arthritis was mentioned in one village while turnip soup (also used topically) was the remedy for arthritis in another village. Undoubtedly there is a correlation between the local availability of these resources and their use.

tence. The popular esteem of and reverence for milk and barley products and their use as virtual medicines may reflect the extend to which common householders feel disenfranchised from the current trend of commodification of medicines and health care in northern Yunnan Province and may therefore represent a form of 'everyday resistance' to this trend. Among Rgyal thang Tibetans, 'resistance' may be in reference to professionalisation and commodification, yet when understood in the wider perspective of the multi-ethnic makeup of the area and the dominance of state discourse, 'resistance' becomes directly linked to ethnic identity.

CONCLUSION

The use of milk and barley among Rgyal thang Tibetans is not new; the utilisation of these products can be seen throughout various Tibetan and trans-Himalayan communities and is not necessarily a by-product of contemporary sociopolitical China. In fact, it is precisely because of the long history of the consumption of these products in Tibetan communities, and their contemporary widespread usage, that they can so artfully be employed as markers of tradition and identity. In order to understand the significance of these products in contemporary Rgyal thang, what these products mean or signify to local Tibetans—in short, to give a 'thick description' of them—we must place them in the context of related discourses of medicinal plant knowledge loss and commodification of medicine in the area. In Rgyal thang, milk and barley as virtual medicines symbolise a resistance to the displacement of local knowledge of medicinal plants and 'traditional' home healing practices by professional, commodified medicine. In addition, milk and barley act as ethnic markers among a populace in which ethnic identity is an important element in the construction of subjectivity. Thus, what may appear to be a most basic fact of life (the consumption of and reverence for staple foods) may actually contain significant hidden transcripts that comment on larger social, cultural, economic, and political events.

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PART THREE:
BODIES, SPIRIT(S) AND ILLNESS

ENGAGING THE SUBTLE BODY: RE-APPROACHING *BLA* RITUALS IN THE HIMALAYAS

BARBARA GERKE

INTRODUCTION

This study deals with the concept of a 'subtle life essence', known in Tibetan as *bla* (usually pronounced 'la'), which pervades Tibetan and Himalayan folk, literary, medical, astrological and religious practices. The author suggests that the diverse practices of *bla* appear with great variation among the enclaved populations across the Himalayas.[1] Their origins might even go back to a pre-Buddhist folk concept found throughout the region, since we know that in early sources the terms *lha* ('deity'), and *bla* seem to be used synonymously, such as in *sku bla*, which means 'personal guardian deity'.[2]

Bla beliefs and practices are complex and ambiguous, and to date have not been researched well enough to define a clear overview. The 30 seats of *bla* in the body, known as *bla gnas*, appear only in classical Tibetan medical and some astrological texts, and are said to originate from the Indian *Kālacakra Tantra*.[3] *Bla gnas* are unknown in the *bla* folk practices of the Yolmowa or Tamang mentioned in the ethnographic examples of this paper.

The Sherpa, Khumbo, Yolmowa and Dolpowa, among whom anthropologists have witnessed *bla* rituals, belong to the enclaved pop-

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[1] The practices are also prevalent in Mongolia and Buryatia. A few years ago, I came across a Buryat manuscript describing the flow of *bla* in horses. *Bla* also corresponds to concepts of the Northeast Thai khwan discussed by Tambiah (1985), the notion of rewaay or 'head soul' studied by Roseman in Malaysia (1991), and the Mongolian *süns* elucidated by Bawden (1962).

[2] The cult of *sku bla* in relation to royal religion was first analysed by Ariane Macdonald (1971) and further discussed by Karmay (1996) and points to the existence of a *bla* of a (royal) family, or even a whole nation. For a general overview on *bla* in relation to *lha* see Samuel (1993: 186–91).

[3] There may be Indian parallels to the seats of passion in women, which partly correspond to the *bla gnas*. See Burton's translation of the *Ananga Ranga* for details at http://www.sacred-texts.com/sex/ar/ar04.htm (accessed on 26.8.2004).

ulations of the high Himalaya who have integrated Tantric Buddhism into their indigenous shamanic practices at various stages in history. These populations themselves are greatly sub-diversified and do not constitute a single ethnic group and identity, "although sharing a common socio-cultural infrastructure of Tibetan origin".[4] The ethnic Tamang and Gurung have been influenced by their northern as well as southern neighbours with overlapping Buddhist and non-Buddhist streams, and do not show unified identities.[5] Thus, we cannot assume the uniformity of *bla* concepts across the Himalayas, and generalised conclusions about a common early origin of *bla* are also impossible. Moreover, comparative approaches to the diverse *bla* concepts would require a great deal of ethnographic data that does not exist at this point of time.

This is therefore a preliminary study[6] and the explanations it provides are based on classical Tibetan medical texts and on two ethnographic studies of the Yolmo (Desjarlais 1992) and Tamang communities in Nepal (Holmberg 1984, 1989). More ethnographic research would be needed to arrive at a comprehensive understanding of the interface of life forces in the medical as well as folk traditions of *bla*. The first part of this chapter explores the various meanings of *bla* and how it has been described in classical Tibetan medical texts. The second part analyses sense perceptions within *bla* rituals based on Desjarlais' and Holmberg's ethnographies.

Existing anthropological studies on *bla* are rather recent (Desjarlais 1990, 1992, 1996; Diemberger 1993; Holmberg 1984, 1989; Mumford 1989; Sagant 1996; Steinmann 2001), and textual materials on the *bla* rituals are few (Bawden 1962; Norbu 1995; Karmay 1998). Hence, this chapter will only suggest areas and approaches for future research on *bla*, rather than presenting definite conclusions.

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[4] A.W. Macdonald 1989: 167, quoting Jest 1975: 35.

[5] In fact, "Tamang identity in so far as it can be said to exist is a Nepalese administrative invention and a concept formulated by non-Nepalese researchers to facilitate written communication between themselves" (A.W. Macdonald 1989: 176).

[6] This chapter is based on my MSc Dissertation in Medical Anthropology (ISCA, Oxford 2003) which was based on library research, and it therefore does not include any of my own ethnographic fieldwork data.

I. Approaching the Meaning and Translation of *Bla* in Medical and Anthropological Contexts

Based on an analysis of the existing literature on *bla*, it may be said that *bla* deeply influences the body's vitality. It radiates its own light, which is visible through a person's lustre and behaviour. Loss of *bla* leads to melancholy, depression and indifference. To gain control over *bla* means to gain control over the person (Tucci and Heissig 1980: 192). *Bla* is vulnerable, because it can be injured, lost during fright and shock experiences, and is also subject to wear and tear.

The meaning of *bla* evolves from the notion of what could be rendered into English as 'subtle life essence',[7] but is in fact more complex considering the internal and external manifestations of *bla*, as well as the shamanic and Buddhist historical influences that have shaped body concepts, perception and ritual practices in the Himalayan enclaves. Tibetan-English dictionaries offer a variety of translations for *bla*.[8] Apart from the literal meaning 'higher' or 'above', the most commonly adopted form of translation is 'soul'.[9] I find the translation of *bla* as 'soul', especially in anthropological works, to be unsatisfactory for several reasons. Firstly, the notion of 'soul' is strongly rooted in Western religious thought and does not reflect the numerous cultural meanings that *bla* has acquired in Buddhist and non-Buddhist contexts among Himalayan communities. Secondly, 'soul loss' is an anthropological invention of the early 20th century that had appeared while studying the temporary absence of some unidentified life force among certain cultures.[10] Thirdly, *bla* has most commonly been translated as 'soul' probably because the European connotation of a subtle body that is capable of leaving the coarse body has survived most

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[7] 'Subtle' here refers to the invisibility of *bla* as well as its integral part of the Tibetan medical physiology (see appendix for the places of bla in the body). Tibetan concepts of the 'subtle body' (*lus 'phra*) differ widely and cannot be dealt with in this paper.

[8] For example, "soul, life, strength, power, vitality, blessing" (Jäschke 1995: 383).

[9] Roerich 1986: 249; Das 1991 [1902]: 899 and Jäschke 1995 [1881]: 383—the latter two quoting Schmidt according to oral traditions.

[10] For example, the numerous studies on *susto* (fright) in Mesoamerica contributed to the use of the general term 'soul loss' in anthropological studies.

prominently in the Platonic notion of the 'psyche'.[11] Another viewpoint to be considered also is that

> the subtle body has been one of the hardest concepts in Buddhist and Hindu thought for Westerners to appreciate, perhaps because it implies a lack of separation between 'body' and 'mind', which Western science has had difficulty in accepting (Samuel 1993b: 237).

I am not suggesting here that *bla* is the same as the Indian Tantric concept of the subtle body, but only that a certain ethnocentrism within North American and European intellectual circles has led to a misunderstanding of the concepts of the body and its subtle physiologies found among other cultures, which in turn may have supported the translation of *bla* as 'soul'.

In anthropology, 'soul' came to stand for "the specifically 'pre-Cartesian' nature of primitive thought (just as 'mind' may invoke a specifically Cartesian view)" (Lambek 1998: 120). In the case of 'soul loss' studies, this division has supported interpretations that focused on binary oppositions. Concerning *bla* rituals in the Himalayas, this has happened along the lamaist-shamanic divide (e.g. Mumford 1989; Ortner 1995). It is important to challenge the etic categories that often remain embedded in anthropological research. Anthropologists may thus need a more differentiated approach in their study of *bla* and of the concepts of the subtle body, especially when dealing with as ethnically diverse a people as the Himalayan communities.

Apart from 'soul', *bla* has also been translated as "spirit" (Desjarlais 1992), or as "shadow souls" (Holmberg 1989). Although Steinmann (2001: 182) translates the Tamang '*pla*' as *l'âme* ('soul'), she points out that the meaning of this *bla* concept forms a point of controversy between Tamang shamans and lamas, because of its multiple forms of existence. Most Buddhist populations in the Himalayas assign one *bla* to each person, though the Tamang, for example, can have nine *bla*, all but one of which can leave the body and become lost (Holmberg 1989: 154). Tamang lamas and shamans apparently disagree on the precise numbers of *bla* (Steinmann mentions that there can be one, three, seven or nine). Because of its multiple existence, Steinmann notes that the Tamang lamas prefer to talk of *bla* as a form of spirit or *rnam shes* (Steinmann 2001: 185).

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[11] Claus 1981. Claus shows that the pre-Platonic 'soul' comes close to a notion of life force, whereas, since Plato, the 'soul' has become more personalised in European thought.

We consequently have to accept the fact that there is no single Tibetan idea of *bla*, but rather a complex of *bla* concepts with multiple points of origin. *Bla* plays an important role in several life contexts. Karmay (1998) describes it as the most important part of the triad of physiological principles in which the others are 'respiratory breath' (*dbugs*) and 'vital force' (*srog*), as well as of the triad of intellectual principles along with the principle of 'thought' (*yid*) and 'mind' (*sems*). In Tibetan astrology, *bla* appears along with *srog* (life force), *lus* (body), *dbang thang* (power) and *klung rta* (good fortune), and forms a part of astrological calculations, predictions and divinations. Some astrological handbooks carry charts of the *bla gnas* for human beings and horses (e.g. Dorji, personal collection Jampa Kalden, Kalimpong 2004). In Tibetan medicine, *bla* is deeply interconnected with longevity, the 'lifespan' (*tshe*) and other 'life forces' (e.g. *srog*), as well as the vital principle of bringing forth radiance (*mdangs ma*). *Bla*—as long as it remains in the body—is bound to a specific circulatory motion in relation to thirty places within the body (*bla gnas*). In Himalayan folk traditions *bla* also has its external manifestations and extends into geographical and sacred landscapes. Diemberger therefore suggests that *bla* "could have been part of a complex of beliefs which related clan territory to its sacred mountain and ancestors" (Diemberger 1993: 114). *Bla* can thus live in 'trees' (*bla shing*), 'mountains' (*bla ri*) and 'lakes' (*bla mtsho*), and can also reside in precious stones such as the 'turquoise' (*bla g.yu*). The following sections will look at some of these aspects in more detail.[12]

THE LOCATIONS OF *BLA* IN THE BODY (*BLA GNAS*)

In classical Tibetan medical literature, *bla* is described as mobile but is still bound to specific 'locations in the body' (*bla gnas*), where it is said to unfold its maximum potency at the areas corresponding to the joints (Gyurme Dorje *et al.* 1992: 39). The *Vaiḍūrya sngon po* commentary written in 1687–1688, quoting from the *Kālacakra Tantra*, mentions that during the waxing moon cycle the *bla* travels through the right side of the body in men and through the left side in women, until on full

[12] This essay cannot deal with all aspects of *bla*. My upcoming doctoral dissertation will provide more details.

moon it reaches the head and for a short while penetrates the entire body (see appendix). During the waning moon cycle *bla* travels through the left side of the male body and the right side of the female one, till it reaches the first joint of the big toe again during new moon (Sangs rgyas rgya mtsho 1982: 107; Gyurme Dorje *et al.* 1992: 39). Interestingly, each *bla gnas* has an associated sound attached to it (see Figure 1) which does not move along with the motion of *bla.*[13]

Figure 1: Sounds are attached to the *bla gnas*, which correspond to joints in the body. The letters are the same on both sides, but differ in the length of their vowel sounds (Gyurme Dorje *et al.* 1992: 40).

Bla in Contemporary Tibetan Medical Practice

Tibetan medical teachings on *bla*, with which I became familiar with during my studies of Tibetan medicine in Darjeeling in 1992/93, explain the taking of the '*bla* pulse' (*bla rtsa*) at the arteria ulnaris on both wrists, and also the movement of *bla* through the body. Medical students are taught that invasive therapies like moxibustion, golden needle therapy and bloodletting should be avoided on days when the *bla* would reside at the corresponding location in the body, and especially on full moon days when *bla* would for a short period pervade the entire body. *Bla* can also leave the body through the ring finger at night, and can be stolen by a demon if the 'life force' (*srog*) is low (Gyurme Dorje *et al.* 1992: 139).[14]

The *Four Tantras* (*Rgyud bzhi*) devote section 13 of chapter one of the *Last Tantra* (*Phyi ma'i rgyud*) to the examination of the *bla* rtsa.

[13] However, further research is still required to understand the relationship between the associated sound and *bla*.

[14] Steinmann mentions that the '*pla*' among the Tamang is said to leave the body through the top of the head (Steinmann 2001: 162).

The *bla rtsa* is deeply linked to concepts of longevity, in particular the 'lifespan' (*tshe*) and the 'life force' (*srog*). The *bla rtsa* is felt in order to diagnose the quality and strength of *bla* and to make predictions about one's lifespan; one regular pulse beat is said to correspond to one year of life and a hundred healthy pulse beats to a lifespan of a hundred years (Gyurme Dorje *et al.* 1992: 139). The amchi diagnoses through the *bla rtsa* whether *bla* has been lost or taken by a spirit, and whether the subject will become a victim of gossip or lose his wealth. Interestingly, the prognosis varies "depending on whether the subject [i.e. the patient] is a religious practitioner or an ordinary person" (Gyurme Dorje *et al.* 1992: 139), a distinction we will also come across in the analysis of sense perceptions of *bla*.

The Social and Spiritual Landscapes of *Bla*

Among contemporary populations in the Himalayan enclaves, the notion of *bla* appears in multiple contexts: as part of ritual practice in the various schools of Tibetan Buddhism, in amchi medical traditions, in Tibetan astrological calculations, and in folk beliefs and shamanic trance rituals. All these may have differing origins, but are nevertheless fluidly interconnected with each other. Buddhist and shamanic traditions differ and often oppose each other in their philosophies but, interestingly, are interrelated in practice, creating what Holmberg calls an "order in paradox" (Holmberg 1984, 1989). The interface of *bla* practices extends from the individual body to the social, spiritual and spatial bodies of the communities.

Stein has noted that geographical representations of *bla* were common in Tibet. The macrocosmic *bla* resides in the *bla gnas* of a landscape as extension of an individual, a group or a country. For example, a lama may have a '*bla* mountain' (*bla ri*) and turning the soil of this mountain might cause him illness, while in families, turquoise stones hold the collective *bla* (*bla g.yu*) (Stein 1993: 271). The *bla g.yu* was worn on the upper part of the body among persons of high social rank (Karmay 1998: 337). *Bla* extends in such cases to the expression of vitality and social power or status. A Dunhuang text mentions a broken turquoise being associated with the death of a leader (Karmay 1998: 320). During the *bla* ritual the lama ties a *bla g.yu* around the neck of

the devotee, who in turn has to care for it since its loss or damage would affect his own *bla* (Karmay 1998: 318). Among the Tamang, '*bla* trees' (*bla shing*) are planted to enhance the life force and create a place of worship for the family (Holmberg 1989: 155). The collective *bla* may also be present in a mountain, e.g. Mount Kailash is the *bla ri* of Zhang zhung. These examples show the fluidity of the relationship between micro- and macrocosmic manifestations of *bla*.

Where *bla* becomes embodied in stones, trees, lakes and mountains, it extends its meanings into the cosmologies of the people and their interrelationship with the individual, the social and the spiritual. These links to a geographical embodiment of spiritual forces and a spiritual embodiment of social forces may either be weakening or empowering. For example, as the *bla ri* of the former Zhang zhung kingdom, Mount Kailash is said to be the "heavenly cord" which links heaven and earth (Tucci 1980: 213, 219). Here, *bla* seems to extend from the microcosmic body to the macroscopic space and thus links heaven to earth, giving a seat to the sacred, a place to community vitality and protection to the country. Karmay writes that according to the systematised Bon religion, *bla* is seen as having the nature of light and relates to the sky (Karmay 1987: 100). Sometimes, the external seats of *bla* are kept secret and are only identified in religious texts, a notion which Huber (1999) has analysed in the context of sacred landscapes around Mount Kailash. Some of these sacred sites are also included in the ritual journeys of the Yolmowa *bombo* ('shaman') on their way to find the lost *bla* (Desjarlais 1992: 218–19).

Diemberger sees *bla* among the Khumbo in Nepal featuring as a constantly redefined cognitive category that links religion, kinship and politics (Diemberger 1993). She interprets the human body as language and order where ties by 'blood' are matrilineal and ties by 'bone' are patrilineal, while *bla* relates to the 'landowners' or the protectors of the local mountains. '*Bla* mountains' (*bla ri*) and '*bla* lakes' (*bla mtsho*) are thus seen as "protective fathers and mothers of the area" (Diemberger 1993: 113). Supplementing such identifications, *bla* can be explained further in terms of the "body ecologic" (Hsu 2001), which looks at the ecological environment as being mediated through social practice and culture-specific concepts that shape body perceptions and medical practice, using the 'body ecologic' as a fluid theoretical concept.

Bla and the Death Process

Confusion however arises when one considers what happens to *bla* at the point of death. Among the Yolmowa, the loss of *bla* is said to cause illness but not death, whereas the loss of 'life' (*tshe*) or 'consciousness' (*rnam shes*) will lead to death (Desjarlais 1992: 139). In contrast, among the Khumbo, *bla* is used as a synonym for *rnam shes*, but is said to return to the Khenbalung Mountain after death (Diemberger 1993: 113). Among the Tamang, lamas conduct rituals during death rites to release the *bla*, which has "a tendency to stray and is perpetually in danger of becoming a part of the world of harmful agents" (Holmberg 1984: 712). The lama thus prepares an effigy of the deceased and attaches a wood-block print, on which the name of the dead person is written, to its head, since *bla* "resides in the print". When the lama burns the print in a butter lamp, the *bla* passes on into the hands of the Buddhas for subsequent rebirth (Holmberg 1989: 210). These examples show that *bla* and *rnam shes* are assigned different meanings in various ritual and practical contexts, which are not easy to decipher.

Avoiding the Shamanist-Lamaist Divide

It thus seems impossible to deduce the historical development of *bla* rituals, and the existing ethnographies reveal that people move quite freely between the shaman and lama, using their services according to their own needs (Mumford 1989). Holmberg shows that among the Tamang in west Nepal, for instance, the 'shaman' who is generally called *bombo* retrieves the lost *bla* while in trance, whereas the Tamang lama summons the *bla* without going into trance, though he still uses shamanic methods in his Tantric rituals. Some of the problems that have arisen during anthropological discussions of these complex lamaist and shamanic practices[15] will be examined in this section.

Shamanic-lamaist binary oppositions have been reiterated by anthropologists, following a basic alignment of shamanism with relationalism and of Buddhism with individualism by two authors (Adams 1992;

[15] See Samuel 1993a for a critical discussion on the use of the term 'shamanism' in Tibetan religion.

Mumford 1989). Sherry Ortner, who critiqued this polarity in her studies on disappearing shamans among the Sherpa, holds that such binary oppositions feed into the unequal discourse of otherness (Ortner 1995: 370). Though it is interesting to show the contrasts in these two ritual approaches, we should not forget that in many ways they overlap, coexist and support each other in daily community life.[16] My intent here therefore is rather to explore the mutual coexistence of various *bla* rituals in the Himalayan enclaves, and the sharing of ritual spaces between Buddhist and shamanic practitioners.

Samuel's distinction between 'clerical' and 'shamanic' Buddhism as an analytical category (Samuel 1993b) is of interest to the context of this essay, because *bla* rituals are adopted in both versions and are dealt with by manipulating and balancing power in the Himalayan communities. While shamans offer to their clientele the manipulation of life forces by 'hooking' the lost *bla* during trance rituals (Desjarlais 1992, 1996) or with the help of sounds (Holmberg 1984, 1989), clerical lamas conduct more elaborate and structured rituals within the 'temple' (*gompa*), without ever going into trance (Holmberg 1984, 1989; Karmay 1998). This has unfortunately often been interpreted as a competition for ritual space between the shamans and lamas (e.g. Mumford 1989). I would call for a more nuanced analysis that respects these complementary practices, along with their regional variations. Multi-cultural societies are common across the Himalayas, especially in modern urban areas. Their people seem to draw from the different traditions of ritual practitioners, whether shamanic or lamaist, and thus create multi-layered ritual spaces with similar purposes.

Thus while discussing the relationship between Buddhism and shamanism, we have to keep in mind the ambiguities present within these controversial terms and avoid such simplifications along the shamanist-lamaist divide. The existing ethnographies represent isolated events drawn from a variety of clerical and shamanic ritual practices across the Himalayas, and we lack adequate data to come to uniform conclusions. By defining the 'lamaist' or 'shamanic' agencies, as well as their relation to Buddhism in each case, we can however ask relevant questions about their co-existence or competition. In order to understand *bla* rituals we must not only look at the relationship between

[16] See for example Balikci 2002 for such a coexistence in a Sikkim village.

'shamans' and 'lamas' (there can be no uniform definition for either of these terms), but also—and this is the new perspective that I would like to suggest—at the notions of 'consciousness' (*rnam shes*), 'heart-mind' (*sems*) and 'subtle life essence' (*bla*), and how they become agents and exert control over each other in the ritual spaces that they seem to occupy simultaneously.

How do *rnam shes*, *sems* and *bla* become agents in rituals? From existing ethnographies we know that the Yolmo shaman hooks the lost *bla* with his 'heart-mind' (*sems*), while the Tamang lama frees the *bla* through the ritual of burning printed letters wherein the *bla* resides. Ultimately they set it free in a flame, which is the flame of 'consciousness' (*rnam shes*) (Holmberg 1989: 210) that appears to be the prerogative of 'civilised shamans'. The *bla* is thus summoned in a peculiar way through the heart-mind or consciousness of the ritual practitioner. I want to look in more detail at the aspects of control in the relationships between *bla*, *rnam shes* and *sems*.

RELATIONSHIPS BETWEEN *BLA*, *RNAM SHES* AND *SEMS*

In Tibetan Mahayana Buddhism, the *rnam shes* is what connects successive existence in the train of karma (one reason for its being related to 'individualism'). This aspect is interesting when used in association to *bla*, which seems apparently to be more one's personal or the community's property (thus having the character of 'relationalism') (Lichter and Epstein 1983: 241). The anthropological discussion on *rnam shes* has centred around the control of pre-Buddhist forces. Adams (1992) has discussed how by giving omnipotence to *rnam shes*, the existence of demons, spirits, etc., as potential causes of illness is acknowledged and at the same time controlled and attenuated. But has the indigenous concept of *bla* really been overlaid and controlled by Buddhist thought? Is Adams' strictly Foucauldian analysis reflected in existing ethnographies, or does it remain a theoretical construct created by a Western anthropologist? We know that some local belief systems use both concepts side by side in a variety of contexts. For example, among the Khumbo Buddhists, Diemberger notes that *bla* is often used as a synonym for *rnam shes,* while local Khumbo perspectives relate *bla* to the local mountains (Diemberger 1993: 113–14). Whether

bla or *rnam shes* control each other may or may not, however, be of any concern for social and ritual reality among the Khumbo, since *bla* is constantly redefined as a cognitive category linking religion, kinship and politics (Diemberger 1993: 114).

It has been an apparent paradox for the concerned anthropologists how *bla* on the one hand has retained distinctive features like its link to the sounds for each *bla gnas*, while it has on the other become an adjunct to distinctive Buddhist terminologies. For example, in medical texts the *bla gnas* have been linked to the Buddhist term for "aspiration to awakening" (Skt. *bodhicitta*, Tib. *byang chub sems*) (Wangdu 1982: 383). Sometimes, *byang chub sems* is even used as a synonym for *bla*. However, on questioning several Men-Tsee-Khang doctors in India on the use of this terminology, they responded that *byang chub sems* is a medical term that has nothing to do with bodhicitta as such.[17] They also pointed me to the (probably originally Tantric) medical term *byang sems dkar po*, which also includes *byang (chub) sems* but is a synonym for the 'white essence' (*khams dkar po*), i.e. the male 'semen' (*khu ba*), just as *byang sems dmar po* is a synonym for the female menstrual 'blood' (*khrag*) (Wangdu 1982: 374). Men-Tsee-Khang amchi thus seem to use these words merely in a medical sense without any Buddhist interpretation. The only explanation for this link between semen/blood and *byang sems* that I have come across so far, evolves around the notion of the body being a 'precious human body' (*mi lus rin po che*). The body is seen as the necessary prerequisite to develop bodhicitta which is a part of the Buddhist teaching, and the foundation for the formation of this human body is seen in the reproductive fluids (*khu ba, khrag*). It might also give us an insight into how Sanskrit Tantric literature and philosophy concerning the 'subtle body' have influenced Tibetan medical literature while being largely ignored (or forgotten?) by present-day Tibetan doctors.

So even if at one point in history, the shamanic *bla* became a part of the Tibetanised subtle body and the Buddhist (*byang chub*) *sems* became an adjunct to *bla*, it does not mean that the amchi today attach any Buddhist import to the notion of *bla*. We therefore have to be careful not to conflate medical with popular *bla* practices in our analysis. My current research, which deals with concepts of life forces in Tibetan societies in India, reveals more pragmatic usages of *bla* in Tibetan med-

[17] In personal communications, August/ September 2004.

ical practice. Mentsikhang clinics generally have a chart of the movement of *bla* through the 30 *bla gnas* on their table, which the amchi consult before applying invasive therapies like moxibustion, bloodletting or golden needle therapy, to avoid disturbances in the flow of *bla*. They admit to its existence quite independently from the three humours *rlung*, *mkhris pa* and *bad kan*, accepting its presence and vulnerability as well as their own medical responsibility for not harming *bla* or causing its loss accidentally.

In ritual practice among other Himalayan communities, things however are less pragmatic. Ethnographic examples reveal how the lost *bla* is not only 'hooked' with *sems*, but is also perceived through its agency. The relationship is thus not only one of control, but also one of mutual interdependence and even support. Among the Yolmowa, *sems* becomes the vehicle of the *bombo*'s journey to find the lost *bla*. When the *bombo* goes into trance to search for the lost *bla*, his *sems* leaves the body with a "joyful, ecstatic shout" (Desjarlais 1992: 204). During the search, while the body is still, the *sems* which has now become the agency of the shamanic journey and the vehicle of shamanic perception reports the experience of being "frightened" and "startled", and can also "walk like thieves" and "keeps roaming" (Desjarlais 1992: 204). The actual moment when the *bla* is being 'hooked' by *sems* can lead to a sudden shaking and fierce chanting of the *bombo*, to which the audience responds in shouts of celebration. The exit and re-entry of *sems* from and into the body is marked by sudden bodily experiences and physical events, which are visible to the audience and links them to the invisible journey. Among the Yolmowa in Nepal, *sems* thus seems capable of experiencing the trance journey, and of recognising and hooking the lost *bla*.

In summary of this first part of my chapter, it would thus appear that the introduction of Buddhist concepts to the Himalayan enclaves could not eradicate the prevailing indigenous view that illness can be caused by a loss of *bla*. The notion of *bla* survived within the interface of Buddhist and non-Buddhist body concepts receiving various interpretations within the different ritual and practical contexts of shamanic, tantric, monastic, astrological and amchi medical practices. The second

part of this chapter suggests an alternate approach to existing anthropological perspectives on the study of the subtle life essence and its loss.

II. Analysing Sense Perceptions in *Bla* Rituals

This section draws its examples from two existing *bla* ethnographies, which have reported on sense perceptions in *bla* rituals. I critically analyse these ethnographic examples in an attempt to incorporate direct sense perceptions into our understanding of the social. How do people know about and perceive *bla*? One way to answer this question could derive from the anthropology of the senses, similar to what Roseman had shown for the Temiar trance performances in Malaysia (Roseman 1991).

The cultural notion that in Tibetan societies, sense perceptions are not limited to the five common senses of the coarse body and that perceptions are graded depending on the level of spiritual attainment, is important for an analysis of sense perceptions during *bla* rituals. It is widely accepted that religious practitioners perceive the same events differently from laypersons, as Huber has shown for example in the context of Tantric practices and visionary landscapes (Huber 1999: 76). With regard to *bla*, it is accepted that *bombo*s and lamas are able to perceive *bla* with their spiritual cognition, whereas lay patients need to feel better to sense its presence. In the medical context we have already seen that the interpretation of the *bla* pulse differs between the lay patients and Buddhist practitioners (Gyurme Dorje *et al.* 1992: 139). The following ethnographies provide examples of various methods of perceiving *bla*.

The shaman's ways of learning about *bla* are derived from direct body perceptions. A Tamang *bombo* narrates,

> When they [the *bombos*] go into the divine [reveal], they do not know what hits them. They do not see with their own eyes. They only know by a sensation which comes around their heart (Holmberg 1984: 708).

The sensation around the heart is a subtle, indeterminate feeling that is characteristic of the *bombo's* way of learning about *bla*. On the other hand, the Tamang lamas neither go into trance nor on a journey to find the *bla*, for which the shamans despise them. While they search, the *bla* appears before their inner eye "as a pure emanation, 'white like milk,

clear like water'" (Holmberg 1984: 712). The 'heart-mind' (*sems*) travel of the shaman is thus transformed into an inner image of the mind and the *bla* is mastered through "the power of the Buddha" (Holmberg 1989: 711).

How do patients experience the loss or return of *bla*? In Yolmo, Dawa learnt about his loss of *bla* from recurrence of dark dreams and from symptoms of feeling dizzy and heavy and a tendency to faint. Dawa was also diagnosed by a shaman's divination, since "the Gods cannot be seen" (Desjarlais 1992: 225). Dawa clearly perceived the return of his *bla*. "When the spirit returned to my body, I felt well, I felt happy, comfortable. I felt a little lighter by next morning. Slowly, slowly, within ten, fifteen days I was fine" (Desjarlais 1992: 225). Dawa also dreamt of walking uphill gazing upon a bright and clear light, which was interpreted as an auspicious sign signifying the returned *bla*.

Desjarlais who focused most of his ritual analysis of *bla* on sense perception, elaborates on the visceral engagement with the senses during *bla* rituals, which offers a lot of insight into the 'somatic modes of attention' (Csordas 1993).[18] He shows how "images, actions, tastes, and sounds speak directly to sensory experiences, as if the body was the true audience and its language one of gesture, sense and image" (Desjarlais 1992: 220). He also focuses on the sensory engagement of the patient, which causes 'presence' (Desjarlais 1996). For Desjarlais this engagement in itself is curative. The aesthetic form of the ritual—imaginative, tactile, precise—prompts attention and awareness. Thus the loss of *bla* is defined by a "lack of engagement", the "singular antidote" to which is "participation" (Desjarlais 1992: 215).

Although Desjarlais advances the useful idea of "somatic sensibilities" (Desjarlais 1992: 150) in his analysis, he unfortunately reduces the entire ritual event to sense engagement and participation. By reducing *bla* to a "semantic category" (Desjarlais 1992: 151), he further limits the challenge of employing theories of embodiment and phenomenology to an understanding of the indeterminate reality of *bla*. For him, the loss of *bla* is "a metaphor for the interactive self" and the actual loss is

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[18] 'Somatic modes of attention' are "culturally elaborated ways of attending to and with one's body in surroundings that include the embodied presence of others" (Csordas 1993: 138). The main contribution of observing somatic modes of attention is that it does not lead to speculations on the inner psychology of the people we study, but rather respect their indeterminate experience of a subtle world, which is a part of their reality.

the "loss of integration" with society, which "equates with a loss of a sense of spirit and vitality" (Desjarlais 1992: 148, 155) but not with the loss of *bla*. By metamorphising *bla*, he neglects the physiological reality that the people attribute to *bla* as well as their 'somatic modes of attention'.

In studying the engagement of the body in *bla* ritual healing, we can look at those aspects of the ritual process where the body simply engages in sensory experience. An example: once the lost *bla* returns, the patient is touched everywhere with various ritual objects. The shaman explains, "we need to touch everywhere to assure that the spirit (*bla*) returns to the body, and to give power to its different parts" (Desjarlais 1992: 205). Desjarlais argues that the patient's senses are engaged and drawn into the present by these touches. On its return, *bla* falls onto the shaman's drum "in the image of three white flowers the size of specks of dust" (Desjarlais 1992: 205). The flowers are dropped from the drum into the food that the patient eats. The senses of vision, touch, smell and taste are thus clearly engaged in the encounter of the subtle with the mundane. The sense engagement seems the only way to make the patient feel the invisible.

Among the Tamang sound can be a carrier of *bla* and the syllable "*ki*" pronounced by the lama to 'hook the *bla*' is an embodiment of a force that actually summons the *bla*. As a bombo says, "The bombo speaks from the stomach (...) lamas read from books, *bombo*s must speak from their mouths. All comes from the innards" (Holmberg 1989: 149). The lama's recitation differs from the *bombo*'s words, but in both cases sound is the essential carrier of the force that hooks the *bla*. *Bla* is also said to "hear" and can thus be guided through sound and ritual chants. Holmberg calls *bla* rituals "soundings", since "the words of their chants hook the *La*" (Holmberg 1984: 712). "Soundings" may in fact also "reinforce, invert, negate or diffuse social relations of power" (Roseman 1991: 16).

On first sight, it seems that the '*bla*-hooking' techniques that evolved over a long period of interactions between *bombo* and lamaist forms (we do not know for certain which of the two indigenised the other at what stage), underwent a transformation from a physical-sensational to a more abstract and intellectual activity. There seems to be an explicit difference in 'somatic modes of attention' between *bombo*s

and lamas, suggesting that the *bombo*'s experience is somewhat more 'embodied'. Things are, however, not that simple, and I would argue for a more nuanced position, where the 'physical imagery'[19] of the lama is as much a form of embodied knowledge as the heart sensation of the *bombo*, so that it is not appropriate to judge whose perceptions are more embodied. Whether we hear about sensations around the heart, or appearances before the inner eye, "we need to take seriously the indigenous claim that these phenomena are forms of perception" (Csordas 1993: 148).

In the case of the Tamang bombo, his 'embodied history'or 'habitus'[20] is carried by the dbang (in Tamang *wang*), which comes from the bombo's personal *lente* (ancestral spirit) and is transmitted to him through his teacher in a culturally 'learnt' way, through decades of training. It includes the experiences of all previous *dbang* across many generations, which also extends into the community as an 'inherited experience'. The dbang is transmitted from teacher to apprentice. It "accumulates in the guru's drum and/or his water vessel and is fed to the apprentice, who upon ingestion shudders and shakes, generating internal strength" (Holmberg 1989: 150). Thus, the transmission of dbang is connected to sense experience: the sound of the drum, or the taste, tactual and olfactory sensations of the water, and its internal touch during ingestion. The senses seem to be an important medium for the transmission of power, in addition to the ritual objects used. The ritual framework may be seen as the space in which the ritual objects enhance pre-reflective sensual experiences. The ritual objects are experienced by the apprentice and become a felt and embodied link between teacher and disciple.

The following quote by Merleau-Ponty, who tries to go 'below thought' to understand perceptual consciousness, may inspire a perspective which includes direct sense perceptions in our understanding of the social (2002 [1962]: 362):

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[19] Csordas proposes 'physical imagery' as a descriptive term for spiritual inner images (Csordas 1993: 147).

[20] I am referring here to Bourdieu's definition, "the habitus—embodied history, internalised in a second nature and so forgotten as history—is the active presence of the whole past of which it is a product" (Bourdieu 1977: 56).

> ... the mistake lies in treating the social as an object. We must return to the social with which we are in contact by the mere fact of existing, and which we carry about inseparably with us before any objectification.

Summary and Concluding Remarks

This chapter has analysed the complex and at times contradictory concepts of a subtle life essence, called *bla*, found among various populations of the Himalayan enclaves. The two ethnographic examples on *bla* rituals among the Yolmowa (Desjarlais 1992, 1996) and the Tamang (Holmberg 1984, 1989) in Nepal have shown that *bla* pervades the physical, social, spiritual and environmental bodies of the community in various ways. Its loss and ritual 'hooking' not only touches upon issues of health and illness, but also involves social disharmony, religious and moral concepts, and political power. Hence *bla*, as one of the life forces, creates networks between different spheres of life and interweaves with the individual, society, the supernatural, sacred landscapes and the local cosmology. These networks cannot be satisfactorily understood through limited anthropological approaches that focus on binary oppositions between shamans and lamas, reduce ritual efficacy to sense engagement, or relate the control of the pre-Buddhist *bla* to the dominance of the Buddhist notion of 'consciousness' (*rnam shes*).

The pervasiveness and ambiguity of *bla*, including its unique relationship with Buddhist notions of 'consciousness' (*rnam shes*), 'bodhicitta' (*byang chub sems*) and the 'heart-mind' (*sems*), empowers its existence and influences its effectiveness. Its interconnectedness with other areas of life supplies the people with numerous opportunities to understand and express individual distress or public concern in culturally acceptable ways. Ritual practice plays a great part in these negotiations of *bla* and its loss, and ritual specialists—whether a *bombo* or a lama—hold a crucial role in these performances. Tibetan astrologers and medical practitioners further enlarge these kaleidoscopic dimensions of *bla* practices, making unified conclusions on *bla* infeasible. The meanings attached to the existence of *bla* and the agencies admitted to it differ widely, and cannot be generalised and explained outside their respective contexts. Because of the existing variations, a pan-Himalayan analysis of *bla* practices would in fact be a cross-cultural analysis.

All fieldwork reports are by definition inadequate to cover such complex issues. Since we can never construct a complete picture, ethnographies are accumulative and have to build on each other. This chapter explored the involvement of direct sense perceptions in only three *bla* rituals from existing ethnographies of the Nepal Himalayas (of a Yolmowa and a Tamang *bombo*, and a Tamang lama) to suggest an anthropological approach that could be developed further to allow a broader understanding of the direct perceptions of patients as well as ritual, medical and astrological practitioners in their attempts to diagnose, reveal, protect or 'hook' the *bla*.

Future research on *bla* could analyse ways in which ideas of *rnam shes, sems* and *bla* have occupied the same cognitive space that consequently may have transformed the ideas of health and illness. How and in what ways have relationships between *bla* and longevity, and other life forces and essences (e.g. *srog, tshe, dbang thang, mdangs ma*) pervaded pan-Himalayan practices at various levels?

Moreover, future research questions could also centre around the changing perceptions of *bla* and its 'body ecologic'. Migration and modernity have affected the social security that was previously believed to be given by the *bla* mountain and *bla* lake. It can be expected that the external manifestations of *bla* may disappear or change along with the loss or destruction of sacred landscapes, which may alter the meaning given to them, and will consequently affect the individual and social perceptions of *bla*.

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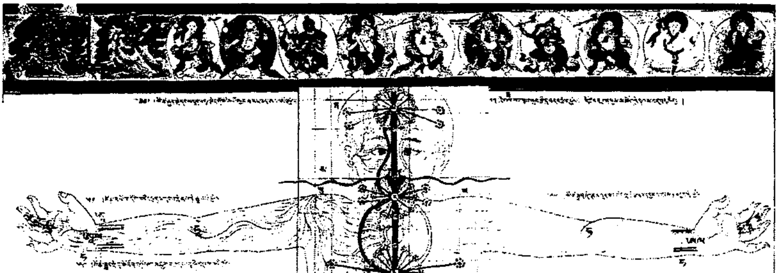
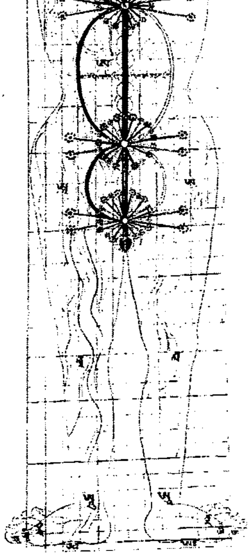
APPENDIX
THE THIRTY PLACES OF THE *BLA* (*BLA GNAS*) AND THEIR SOUNDS

Modified from a Tibetan medical mhanka of the 17th century (Gyurme Dorje *et al.* 1992: 40).

During the waxing moon cycle the *bla* travels through the right body side in men and the left side in women. During the waning moon cycle the *bla* travels through the left side of the body in men and the right side in women. This thanka depicts the male cycle (Gyurme Dorje *et al.* 1992: 39).





Bla movements during the waxing moon cycle

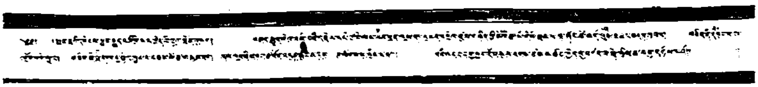
1. On the first day (after new moon), the *bla* resides in the letter A at the big toe joint; then it moves through
2. I at the second joint of the big toe,
3. RI at the third joint of the big toe,
4. U at the anklebone,
5. LI at the knee,
6. A at the junction of the hip,
7. E at the first joint of the middle finger,
8. AR at the second joint of the middle finger,
9. O at the third joint of the middle finger,
10. AL at the wrist,
11. HA at the elbow,
12. YA at the shoulder,
13. RA at the throat,
14. VA at the big fontanel, and
15. LA at the forehead.

15./16. On full moon, through the form of OHM at the crown of the head the *bla* again moves, in form of LHA.

Bla movements during the waning moon cycle

Bla moves through
17. VHA at the neck,
18. RHA at the heart,
19. YHA at the shoulder joint,
20. HHA at the elbow,
21. AHL at the wrist,
22. OH at the third joint of the middle finger,
23. AHR at the second joint of the middle finger,
24. EH at the first joint of the middle finger,
25. AH at the junction of the hip bone,
26. LHI at the knee,
27. UH at the ankle,
28. RHI at the third joint of the big toe, and
29. IH at the second joint of the big toe.

30./1. On new moon *bla* resides in the AH at the first joint of the big toe and at the sole of the feet.



SPIRIT CAUSATION AND ILLNESS IN TIBETAN MEDICINE

Geoffrey Samuel

Illnesses of one kind or another are explained through the action of spirits in many cultures. Tibetan ideas about spirit causation are only one of many Asian examples. The situation becomes more interesting when we consider which kinds of illness are explained in this way, which spirits are involved, and what the implications are of the modes of treatment used. These are the questions I will be looking at in this paper, both on the basis of literary texts, primarily the *Rgyud bzhi*, and ethnographic accounts, including some material from fieldwork among refugee Tibetans in Dalhousie in Northern India in 1996. The present paper is more exploratory than conclusive, but I hope that it will encourage others to take the issues I deal with here further.

Spirits in the *Man ngag rgyud*

The *Rgyud bzhi*, the famous *Four Medical Tantras*, constitute the best-known text of 'traditional Tibetan medicine', to use a term that is not unproblematic, but will serve my purposes here. I also refer to this tradition in the paper as amchi (*em chi*) medicine, after the most usual Tibetan term for its practitioners.

The *Rgyud bzhi*, as we now know, in large part through the work of the late Ronald Emmerick, constitutes a single complex text incorporating material from a variety of different sources. The most important of these is a well-known Sanskrit treatise on Āyurveda, the *Aṣṭāṅgahṛidayasaṃhitā* of Vāgbhaṭa (e.g. Emmerick 1977, 1987). Despite the *Rgyud bzhi*'s Buddhist framework, it is for the most part a medical text with a quite pragmatic orientation to illness and an emphasis on pharmacological and dietary modes of treatment. The question of spirit causation of illness nevertheless arises in a number of contexts in the *Rgyud bzhi*, and I start by considering two of these.

The third and longest of the four parts of the *Rgyud bzhi* is the *Man ngag rgyud* or *Instructional Tantra*. This consists of 92 chapters most-

ly dealing with specific topics (diseases of the eyes, fevers, skin disorders, abdominal injuries, and so on). It also incorporates five chapters, numbers 77 to 81, which deal primarily with illness caused by 'spirits' (*gdon nad*), although the question of spirit related illness comes up in other chapters as well, particularly the two on diseases of children (chapters 72 and 73).

Chapters 77 to 81 are quite interesting. The first three, 77 to 79, are typical of many chapters of the *Man ngag rgyud* in that they are modified and shortened versions of the Tibetan translation of Vāgbhaṭa's *Aṣṭāṅgahṛidayasaṃhitā* (Emmerick 1987). These are the three chapters that Terry Clifford translated in her well-known book *The Diamond Healing: Tibetan Buddhist Medicine and Psychiatry* (Clifford 1989: 171–97). They deal respectively with illness caused by the so-called 'elemental spirits' (Skt. *bhūta*, Tib. *'byung po*), with madness and with epilepsy,[1] and correspond to chapters 4, 5, 6 and 7 respectively of Part VI (the *Uttarasthāna*) of Vāgbhaṭa's work. The first of these chapters, chapter 77 on the *bhūta* spirits, gives a list of eighteen types of *bhūta* which includes all kinds of strange characters—*deva-bhūtas*, *asura-bhūtas*, *gandharva-bhūtas*, *guru-bhūtas*, *ṛṣi-bhūtas* etc (to use their Sanskrit names)—which come straight from Vāgbhaṭa and as far as I know have very little resonance with how Tibetans in modern times think about and deal with illness.[2] Chapters 78 and 79 also seem to reflect Indian rather than Tibetan understandings, and I am not clear how far they relate to Tibetan medical or lay ideas either at the time of composition of the *Rgyud bzhi* or in more recent times.

The following two chapters, 80 and 81, are another matter altogether. Chapter 80 is about the *gza'* spirits who cause strokes and various other kinds of partial paralysis, and chapter 81 is about the *klu* spirits, corresponding to Skt. *nāga*, who cause various kinds of skin diseases, including leprosy. As far as I can tell, these two chapters do not derive from the *Aṣṭāṅgahṛidayasaṃhitā* (which has a quite different treatment of the causes of leprosy and skin diseases in III, 14) nor have I identified any other obvious source.

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[1] Clifford translated *brjed* as 'forgetfulness' but as Emmerick noted (1987) the syndrome identified both in the *Rgyud bzhi* and in the *Aṣṭāṅgahṛidayasaṃhitā* is better translated as 'epilepsy'.

[2] In North India or Bangladesh, by contrast, *bhūta* remain a very important category of illness-producing spirits.

In any case, these chapters deal with spirits which are still very much part of Tibetan ideas about illness-causation in modern times. Presumably they were also important at the time when the *Rgyud bzhi* was compiled. I assume that its redactors felt the necessity of including them because the three Indian-derived chapters did not really cover the topic of spirit causation as it was understood in Tibet at that time.

Consider, for example, the list of actions that can provoke the *klu* spirits given in chapter 81. These include items such as disturbing the water *klu*, cutting down trees in which *klu* live, digging up the earth, or allowing food (especially milk, meat and blood) to boil over onto the hearth while cooking. Compare Sherry Ortner's discussion of ideas about the *klu* in a 1978 paper based on fieldwork among Sherpas in the late 1960s, about eight centuries after the presumed compilation of the *Rgyud bzhi*. I cite Ortner in part because she was working primarily from oral sources, not from texts, and in a culturally Tibetan region where amchi medicine seems to have had little presence (Ortner 1978: 279):

> *Lu* are guardians of the purity of the soil and the streams, and of the houses and their hearths. House and hearth *lu* are primarily offended by foul odors, especially those caused by burning animal matter—meat, milk, hair, nails, bloody cloths, and so on—in the household fire. *Lu* of the outer environment are offended by pollution of that environment—chopping trees in certain areas, and especially dirtying streams and water points with human wastes. Some streams are guarded by particularly touchy *lu*, who will not even tolerate washing one's body or one's clothes in them.

Again in close agreement with the *Rgyud bzhi*, Ortner (1978: 279) goes on to note that:

> *Lu* cause ailments that almost always involved unpleasant visible corruptions of the body—sores and boils, leprosy, physical deformities, swellings and so on.

But I am sure many scholars of Tibet could add examples of their own. To give an instance from fieldwork that I carried out in Dalhousie from June to August 1996 with Linda Connor and Santi Rozario,[3] one Tibetan friend told how as a schoolchild in Dalhousie he used to hang out his washing by a tree in front of the Tibetan refugee school. He

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[3] See Rozario, field notes from 30/7/96, which contain several other *klu* stories.

developed a large boil on his face that failed to respond to any kind of treatment until one of the local lamas worked out that he had offended the *klu* who lived in the tree by polluting its environment with his underwear! He made offerings to the *klu*, found somewhere else to hang out his washing and the boil disappeared.

As for diseases caused by *gza'*, these have been less discussed in the literature but they were quite common in Dalhousie in 1996, where they were more often referred to as *rtsa grib* (pollution of the channels), a kind of euphemism which avoided direct mention of the *gza'* spirits. Our sample of 150 or so patients treated at the local Men-Tsee-Khang clinic over six weeks by the Dharamsala trained amchi yielded a dozen or so *rtsa grib* cases. I described five of these in some detail in a previous publication (Samuel 1999). I will summarise two of them here. These accounts are based on interviews with the patients and their families, so they may represent the patient's own retrospective narrative rather than the literal sequence of events.

> A 76-year-old woman collapsed sixteen years earlier while carrying water in a bucket downhill. She felt as if struck by lightning. Since then she has been paralysed all down the left side of her body. She tried biomedical treatment for one month with one of the local doctors, but it did not help. She took Tibetan medicine for 15 years, receiving free medicine because she and her husband are so poor. She said however that her record book got lost when the previous Men-Tsee-Khang doctor left, so she can no longer get free medicine and has stopped taking Tibetan medicine. She has taken numerous Precious Pills (*rin chen ril bu*) and they help a little.[4] Sometimes she is unable to speak, but recovers after taking Precious Pills for one or two days. She never had any kind of divination for the problem; her husband commented that it was obviously *rtsa grib* so they knew that she wouldn't get much better whatever they did (Samuel 1999, Case Four).
>
> A 32-year-old woman had started suffering from pain and loss of sensation in her left arm the previous year. She suspected *rtsa grib* and consulted a well-known spirit-medium (*lha pa*) in Dharamsala who said that she did indeed have *rtsa grib* and recommended that she treat the prob-

[4] These are special, ritually prepared pills based on the *rasāyana* or alchemical tradition of Indian *Vajrayāna* medicine, rather than on the *Rgyud bzhi*, and generally, as in this case, involving various kinds of mercury compounds. They are considerably more expensive than ordinary pills and are supposed to be taken under specified conditions and accompanied by appropriate mantras, though most people we talked to seemed to be fairly casual about this.

> lem with Tibetan medicine.[5] She also went to the Dalhousie community's lama, who again diagnosed *rtsa grib* and told her to stay 'clean'. She then went to the Men-Tsee-Khang clinic in Dalhousie and saw the Tibetan doctor there who confirmed that the problem was *rtsa grib* and advised her to avoid 'dirty' foods (specifically pork, garlic and eggs). She pointed out to us that she was not always able to avoid eggs because they were cooked into noodle dishes. On this doctor's recommendation[6] she took various Tibetan medicines and also one of the *rin chen ril bu* or 'Precious Pills'.[7] The pills helped, but the problem recurred some months later in her arm and upper back. She was visiting Dharamsala at the time so she went to a well-known privately practicing Tibetan doctor there. He suggested gold needle moxibustion but she came back to Dalhousie and didn't have it. He also prescribed the same medicines as the Dalhousie doctor, and she took these. Again, this helped, but at the time we spoke to her, the problem had just reoccurred, and she had made a couple of visits to the new amchi who had taken over at the Men-Tsee-Khang clinic for further pills (Samuel 1999, Case One).

All the cases we encountered had individual features, but these two are perhaps as typical as any, and they also indicate the range from patients who were largely paralysed to others with less dramatic complaints. In Dalhousie, the *gza'/rtsa grib* complex was only partially linked to *Rgyud bzhi* style medicine, and while most of the *rtsa grib* sufferers we met used Tibetan medicine, they did not seem to have much confidence that it would provide more than limited relief. Virtually all of them used the 'Precious Pills' when they could get them. These Precious Pills were expensive and the supply was limited when we were in Dalhousie. They were much more strongly associated with Vajrayāna Buddhism and the power of the lamas than is ordinary Tibetan medicine, though people generally assumed that the pills from the Dharamsala local Men-Tsee-Khang received some kind of Tantric empowerment as part of their manufacture. As might be expected, the *rtsa grib* patients also used a variety of other *byin rten* (empowered substances) when they could get them.

Certainly Dalhousie Tibetans seemed to have no need of the doctor to diagnose cases of *rtsa grib*, since everyone knew that strokes, partial paralysis, one-sided pains and facial tics and the like were linked to the

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[5] I prefer to translate *lha pa* in this context as 'spirit medium' rather than 'oracle' or 'shaman' though none of these terms is entirely satisfactory.

[6] This was a previous doctor, not the one who was at the clinic during our fieldwork.

[7] Specifically Byur dmar nyer lnga, on which see Aschoff and Tashigang 1997.

gza' deities. They were much more likely to consult a spirit medium—several had been to the spirit medium at Dharamsala—or a lama for a divination as to the best course of action. In either case, they might be referred on to the local Men-Tsee-Khang doctor or another amchi for treatment.

The new doctor at the local Men-Tsee-Khang clinic, while he seemed willing to go along with the spirit causation assumptions of his patients, generally explained their problem to us in terms of *rtsa dkar* rather than *rtsa grib*. *Rtsa dkar*—literally 'white channels'—is the subject of chapter 60 of the *Rgyud bzhi*, and generally glossed in contemporary usage as the nervous system. *Rtsa dkar* as a disease category does not imply spirit agency while *rtsa grib* does, both in that *grib* or pollution generally implies susceptibility to spirit attack, and because in any case it is a recognised euphemism for *gza'* problems. In the cases we observed, the doctor prescribed drugs that were regarded as good for *rtsa dkar* problems while at the same time having some action for *rtsa grib* as well (see Samuel 1999).

SPIRITS IN THE *PHYI MA'I RGYUD*

I shall come back to the two cases I described, but first I want to briefly mention another section of the *Rgyud bzhi* where *gdon nad* or spirit-caused illness appears. This is in the last of the four parts of the *Rgyud bzhi*, the *Phyi ma'i rgyud* (*Additional* or *Subsequent Tantra*), in the chapters on pulse and urine analysis. As I have noted elsewhere (Samuel 2002), these two closely parallel chapters, clearly the work of the same authors, are probably among the most significant sections of the *Rgyud bzhi* in relation to contemporary clinical practice. As far as we know, they are not of Indian origin. Indeed, pulse diagnosis does not feature in the classic Āyurveda texts although it is a significant part of both traditional Chinese medicine and the Greek-Islamic system, with both of which the Tibetans were acquainted.

In both the pulse and urine diagnosis sections, *gdon nad* is a recognisable if somewhat secondary category, and a longish list of miscellaneous spirits is cited, including *klu* but not *gza'*.[8] These sections would, I think, be worth following up further, both in relation to the spirits

[8] Meyer 1990: 235 and especially pp. 248–49 for pulse; my notes for urine.

involved and to how far these procedures are in fact utilised in contemporary practice. As I mentioned earlier, in modern Dalhousie spirit attack, at least *rtsa grib*, is generally self-diagnosed, with confirmation sought from a spirit medium or lama, rather than diagnosed by the doctor, so that pulse and urine diagnosis are not necessarily involved.

DISCUSSION

In the remainder of the paper I want to reflect a little on what sense we can make of the whole business of spirit attack, both generally and in the specific ethnographic situation we encountered in Dalhousie. There are several ways in which we could approach this material, and I will mention three here.

The patient and the cure. If we go back to our two patients, in both cases we appear to be dealing with chronic, long-term ailments where biomedicine, at least as locally available in Dalhousie, has little to offer. As we often hear, amchi medicine is generally considered by contemporary Tibetans to be most suitable for long term and chronic ailments, and these fall very much into that category.

I am not in a position to offer a conclusive biomedical diagnosis in either case. The first patient certainly was heavily incapacitated and probably had had a stroke, the classic result of *gza'* attack. The second, the patient with the pains in her arm and back, was clearly much less incapacitated. Our feeling at the time was that her symptoms probably had as much to do with a general situation of overwork and stress as with anything identifiably medical, but she was undoubtedly experiencing chronic pain. In both cases, the diagnosis provided some degree of support to the patient in a difficult social situation, while also leaving open the possibility of symptomatic relief through Tibetan medicine.

There is a substantial body of material in anthropology looking at practices based around spirit attack as a way of dealing with situations of structural inferiority and vulnerability. We could compare for example Ioan Lewis and Janice Boddy on the *zar* cult of Northeast Africa, Carol Laderman on the spirit cults of Peninsular Malaysia (*main petri*) or, somewhat closer to home, Bruce Kapferer on the *yakṣa* rituals (*yak tovil*) in Sri Lanka (Lewis 1971; Boddy 1988, 1989; Laderman 1987, 1991; Kapferer 1979, 1983; see also Boddy 1994). What these situations all have are elaborate and dramatic modes of dealing with the spirit

attack through ritual means directed very specifically to the patient's individual situation. Could this kind of analysis be relevant here?

Tibetan Buddhism itself has plenty of ritual means of countering spirit attack, though they tend to be rather more generalised in nature. As far as I know none of the Dalhousie patients underwent a full-scale exorcism by a lama or elaborate treatment by a spirit medium or similar practitioner, though they certainly used Precious Pills, *byin rten* and other empowered substances. Some of the Ladakhi material (Day 1989, 1992; Schenk 1993; see also Kressing 2003) would seem to offer a situation closer to that in Kapferer's or Laderman's work, and I think it would be worth doing a wider study of how these kinds of problems have been treated in different Tibetan communities.

In relation to Dalhousie, we need to bear in mind that this is a relatively small and scattered community living in a medium-sized Indian town, and that the Tibetans are making choices between a variety of available healing modalities. Some of the kinds of ritual strategy that might have been efficacious in more culturally homogenous situations might not have had as much purchase here. Equally, access to a competent practitioner of Tibetan exorcistic ritual might have been limited.[9] Even if somebody had been available, our patients might have been unable to afford the expense involved, and unsure whether it would have been worthwhile.

As for *klu* diseases, the cases we came across were mostly in the past, though we did meet a variety of current cases of skin ailments linked to *grib* or pollution where *klu* were not mentioned directly. Possibly some of the complaints that would earlier have been treated as *klu* illness were now treated more effectively by biomedicine. At the same time, many skin ailments are chronic, subject to remission without very obvious biomedical cause, and not all that easy to treat effectively with biomedicine, especially in the Dalhousie situation where people can rarely afford long courses of treatment with Western medicine. Here again, comparative data from situations where *klu* illness is still a significant category for treatment purposes would be worthwhile.

A second level though is to look at the spirits involved in relation to the community as a whole. As Ortner noted in her 1978 essay, ideas about *klu* seem to be saying something significant about human nature

[9] Very few lamas or other Tibetan practitioners in India at this time specialised in exorcistic ritual (Marcia Calkowski, personal communication, August 2003).

and to be linked with more general concerns about purity and impurity. She treats them as a kind of image of what human beings are; a mixture of the animal, organic and impure, and the possibility of purity and attainment of the higher realms that for her are symbolised by the 'gods' (*lha*) in general.

Gza' attack is another matter. As an image for human behaviour, the *gza'*, if anything, would seem to provide a symbolic representation for irrational and scarcely motivated outbreaks of violence. If so, their salience in Dalhousie would make some sense in terms of the nature of refugee life, both in terms of the not always harmonious relationships within the exile community but also the vulnerability of refugee life to the wider Indian environment. Ideas about pollution more generally certainly seemed to be saying something about the difficult and vulnerable situation of refugee life, for example in the concern about pollution that we met in relation to selling sweaters on dirty and polluted Indian streets (Rozario 1996; Rozario and Samuel 2002).

To go back to *klu*, they also, of course, form part of what one could call the embedded ecology (Nagarajan 2001) of everyday Tibetan life. Tibetans avoid—or at least used to avoid—polluting water sources in part out of a concern for possible retaliation by disturbed *klu*. Similarly, illness attributed to *klu* and other local spirits (the *Rgyud bzhi* chapter in fact deals with a variety of other spirits as well as *klu* proper, though it links problems with these other spirits to offending the *klu*) could, at least in the past, act as a context which sets into play communication with the local spirit world via a spirit medium, or through a lama's divination. These, in their turn, might lead to changes in behaviour by the group, as well as the individual, in relation to the environment (cf. Turner 1968, 1975; Samuel, 1990). Local deities are of course also significant figures both in monastic ritual and in the lay incense offering rituals of *bsangs*, though to varying degrees given a Buddhist guise. In these contexts, too, there is a stress on reaching an accommodation, a harmonious relationship with the surrounding spirit world.

It is not surprising that we came across relatively limited evidence for such issues in Dalhousie in 1996, particularly since we were not specifically looking for them, but in fact there was some. Dalhousie has a large refugee school, with about 600 children, and a mixed Indian and Tibetan staff. There were ongoing disagreements about educational policy within the school, in part focussing on the extent of coverage for traditional Tibetan religious topics. This became expressed in part in

terms of concern about the *bsangs* offering rituals performed by the school and pressure by one group of teachers to increase their frequency and elaborateness. The same group were also pressing for the school to consult a senior Tibetan lama elsewhere in Himachal Pradesh for a divination regarding problems with students at the school, clearly in the hope that he would recommend more attention to the local spirits and Buddhist deities and a higher level of Dharmic content in the school curriculum.

But I would like to finish with a *third level*, which is the relation of the spirits to the entire world of Tibetan Buddhism. Here, the illness caused by the *gza'* and *klu* spirits is perhaps more significant than we might at first think. These immediately identifiable syndromes are part of a bedrock of support for a world view in which there are dangerous and threatening spirits which have to be countered and against which the community has to be defended. In this respect there is a close relationship between the spirit world and Vajrayāna Buddhism. As I have argued elsewhere at length (Samuel 1993), a significant part of what Vajrayāna Buddhism offered to early Tibetans at the level of the village community was the promise of effective protection against the spirits active in the environment, thus taking over from the older spirit practices and providing new and more impressive techniques. This, I have suggested, was how Buddhism became a vital part of the village community in the years following the collapse of the Tibetan empire and the disappearance of state support in the 840's.

Thus Buddhism needs the malevolent spirits as a fundamental justification for its own existence, rather as Brahmins need impurity and untouchability in Louis Dumont's famous analysis of the Indian caste system (Dumont 1972). Here I do not mean of course to dismiss the entire soteriological enterprise of Buddhism built around the path to Enlightenment, or the karmic basis of morality within the village and wider community. Both have been central parts of Tibetan communities into modern times. But if we want to ask why they were accepted by ordinary villagers, and why they still maintain a high degree of credibility in communities such as Dalhousie today, we might look to the continuing presence of such obvious and evident signs of the action of the spirits as are provided by the attacks of the *gza'* and *klu*.

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'LIFE-WIND ILLNESS' IN TIBETAN MEDICINE: DEPRESSION, GENERALISED ANXIETY, AND PANIC ATTACK

ERIC JACOBSON

In the study of *gso ba rig pa* (pronounced '*sowa rigpa*'), the Tibetan 'science of healing', anthropological methods can supplement the exegesis of classical texts by providing insight into the contemporary constructions of illness and clinical practices which are justified by reference to those texts.[1] This enables an exploration of the ways in which classical medical theory interacts with the contemporary circumstances of Tibetan life. In addition, cross-cultural psychiatry can situate these aspects of Tibetan medicine in relation to similar medical phenomena in other cultures and civilisations, including those in biomedicine.

CLASSICAL TIBETAN THEORY

The central classic of Tibetan medicine is *The Treatise of Secret Oral Instruction on the Eight-branched Essential Elixir* (*Bdud rtsi snying po yan lag brgyad pa gsang ba man nag gi rgyud, ca.* 11th century CE), more commonly referred to as the *Four Treatises* or the *Four Tantras* (*Rgyud bzhi*).[2] Its vision of physiology and pathophysiology is based on a triad of agents, the 'three trouble-makers' or 'three faults' (*nyes pa gsum*)—'wind' (*rlung*), 'bile' (*mkhris pa*), and 'phlegm' (*bad kan*).[3] Each can give rise to either physiological normality or pathology

[1] This research was supported by NIMH dissertation grant 1 F31 MH1008. Thanks to Byron Good, Alan Harwood, David Healy, Devon Hinton, and Roberto Lewis-Fernandez for their insightful suggestions regarding this chapter.

[2] Throughout the research reported in this chapter, I used the Tibetan Medical and Astrological Institute, Dharamsala edition of this standard Tibetan medical text, see bibliography under BSYB.

[3] The three *nyes pa* correspond exactly to the *tridoṣa* of *vāta, pitta* and *kapha* which play a similarly central role in classical Āyurvedic physiology (Jacobson 2000, Meyer 1996). As others have realised, this, along with the conception of health in the *Rgyud bzhi* as depending on a quantitative balance among the three, is strong evidence of the influence of Āyurvedic doctrine in the formulation of the Tibetan classic.

depending on its deployment in the body.[4] The *Rgyud bzhi* attributes most illnesses to quantitative imbalances or to defects in the circulation of one or more of the *nyes pa*, supplemented in some instances by similar dysfunctions of 'blood' (*khrag*) or of 'yellow water' (*chu ser*).[5] Excesses or deficiencies of any of these agents may occur in any of the seven tissues, eleven principal and vessel organs, or myriad of channels which constitute the physio-anatomy in the *Rgyud bzhi*. The number of possible pathophysiological configurations is thus very high, although the *Four Tantras* enumerate 404 illnesses. In as much as imbalance among the *nyes pa* is the basis of illness, their balance is the key to health.

The etiological theory of *gso ba rig pa* is strongly linked to Buddhist metapsychology. According to classical doctrine both 'essential causes' (*rgyu*) and 'circumstantial causes' (*rkyen*) are necessary for the actual occurrence of any illness. Essential causes are further divided into distal and proximal. The distal essential causes, which are in effect metaphysical origins, are the 'three poisons' (*dug gsum*): 'passionate attachment' (*'dod chags*), 'inattentiveness' (*gti mug*), and 'anger' (*zhe sdang*), which are a basic construct of Buddhist canonical thought.[6] They give rise, respectively, to the three *nyes pa*, 'wind', 'bile' and 'phlegm'. This attribution of the ultimate origin of the *nyes pa* to the 'three poisons', and the correlative equation of balance among the *nyes pa* with subduing the poisons link illness and health firmly to Buddhist metapsychology and morality. Having arisen from the three poisons, the *nyes pa*

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[4] Glosses which also have specific meanings in biomedical or lay American English such as 'wind', 'bile', 'phlegm' and 'blood' are placed in quotes to remind the reader that the Tibetan medical concepts to which they refer, while overlapping those of the corresponding English words to some extent, nevertheless differ in important ways. This convention is also applied to glosses which have no ordinary English or biomedical homonym such as 'life-wind illness'.

[5] Contemporary amchi generally translate *chu ser* as 'lymphatic fluid', and sometimes as 'serum'. Neither equation has been biomedically confirmed. In any case, neither 'blood' nor 'yellow water' are accorded the same primary physiological-pathophysiological status as the three *nyes pa*. 'Blood' is a hot influence like 'bile', and thereby expands the triad of the *nyes pa* to a more thermally balanced tetrad in which those two counter-balance the two cold influences of 'phlegm' and 'wind'. Beckwith (1979) reviews evidence of Galenic influence in the earliest formulations of classical Tibetan medicine, and cites it as the likeliest source of the prominent pathophysiological role which the *Four Treatises* accord to 'blood' in some illnesses.

[6] At the deepest, primordial level the three poisons themselves arise from 'deluded perception' (*ma rig pa*), i.e. the mistaken impression that the self and the world with which it is involved are real. According to Buddhist doctrine this misapprehension is the fundamental cause of all suffering.

themselves then become the proximate essential causes of illness when their mutual equilibrium is disturbed. The second etiological category, 'circumstantial causes', provokes particular occasions of illness by disturbing the balances and flows of the *nyes pa*. 'Circumstantial causes' include variations in season, diet, conduct and the influence of malevolent spirits.

The following verse from the *Rgyud bzhi* lists some of the general 'circumstantial causes' of 'wind illness' (*rlung gi nad*). Several varieties of physical, mental and social suffering are indicated. Note that from a biomedical point of view all of these may be subsumed under the notion of 'stressor'. However, unlike biomedicine, *gso ba rig pa* does not separate physical stressors out from those which we would classify as psychosocial. In this and other passages 'wind' appears as a patho-physiological principal which mediates a wide range of both physical and psychological stressors to specific forms of psychic and somatic suffering.

> [Wind's] circumstantial causes are excessive reliance on bitter, light, and rough [food],[7]
> Fatigue due to passion [i.e. sexual indulgence], eating and sleeping being reduced,
> Strenuous verbal and physical activity on an empty stomach,
> By having bled much, by having violently ejected vomit and diarrhoea,
> Due to being blown on by a cold breeze, uncontrollable crying,
> Worrying, excessive mental, physical, or verbal activity,
> Taking one's fill of un-nourishing food,
> Repressing [bodily] impulses, [or] forcing [the bowels] by pressure.
> Due to these circumstantial causes [wind] at first increases and accumulates in its own [physiological] locations.[8]

Even more immediate factors which promote the breaking out of illnesses due to imbalances which have been building up for some time

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[7] 'Rough' or 'harsh' diet means a diet which is disproportionate in foods which have the quality of 'roughness' or 'harshness' (*rtsub*). This is one of seventeen 'qualities' (*yon tan*) which constitute one axis of the *Four Treatises*' multidimensional classification of the physiological effects of foods. Examples of 'rough' foods are strong tea, certain uncooked vegetables, and goat meat. Spoiled food is also 'rough'.

[8] BSYB, Vol. 3, Chap. 2, ll. 14–22. *De rkyen kha dang yang rtsub bsten drags dang / chags pas dub dang lto dang gnyid chags dang / lto stong lus ngag bya ba drag shul dang / khrag mang zags dang 'khru skyugs drag pos btab / bser bu bus dang ga chad ngus pa dang / mya ngan sems las kha yi las ches dang / bcud med kha zas yen la gtad pa dang / shugs bkag pa dang nan gyis btsir ba yi / rkyen des dang por rang gnas 'phel shing gsog /*

are age, climate, and season.[9] Specific types of phenomena in each of these categories disrupt each of the three *nyes pa*. Thus, for instance, illnesses caused by accumulated imbalances of 'wind' tend to break out in the aged, in locales which are windy and cold, and in the summer.[10]

THE SPECIAL ROLE OF 'WIND'

Among the three *nyes pa* 'wind' has a special role as the principle agent of both psychic and somatic motility. The fact that *rlung* also (and perhaps originally) refers to wind in the external environment, suggests an etymological basis for its adoption as the agent of movement and change.[11] However, except for the understanding that cold breezes disturb the psychophysiological 'wind'; the meteorological and physiological significances of this term are otherwise distinct.

The normal motility of the breath (including speech), bodily fluids, and the musculoskeletal system depend on the presence of 'wind' in proportions equitable to those of 'bile' and 'phlegm', and on its unimpeded circulation through the proper channels, which must equitably distribute it among seven types of tissue, 11 organs and five psychophysiological coordinating centres.[12] 'Wind illnesses' arise if 'wind' is excessive or deficient in any of these structures, or if its flow through the complex system of 'channels' (*rtsa*) is blocked upwardly, downwardly, centri-peripherally or locally.[13] The combination of any of

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9 "These [illnesses] increase [depending] on the nine [factors of] age, locale [i.e. climate], and time [season]" (*na so yul dus dgu ru 'phel byed de*) (BSYB Vol. 1, Chap. 3, l. 45). Each of the three—age, locale and time—have three sub-categories, making nine in all.

10 The circumstantial causes and immediate promoters of 'wind disorder' are given in BSYB, Vol. 1, Chap. 3, Lns. 52–53 and 64–73.

11 The classical elements of Tibetan metaphysics—wind, water, earth, fire and space—are the same as those of north Indian Buddhism which provided its scholastic heritage (Birnbaum 1979).

12 See Kuriyama (1994, 1999) for discussions of the historical development of the analogous ancient Chinese medical concept of *qi* from the meteorological sense of wind. Like the Tibetan *rlung*, *qi* is a dynamic that is fundamental to both physiology and pathophysiology.

13 The Tibetan *rtsa* ('channel' or 'vein') is applied alike to blood vessels, nerves, lymphatic ducts and the conduits of 'wind' (the latter having no clear parallel in Euro-American anatomy). The *Four Treatises* describe a number of different types of 'wind' channels. The 'wind' coordinating centres are located along the central vertical axis of the body. In descending order they are the 'life holding wind' (*srog 'dzin rlung*),

these disturbances with analogous disorders of 'bile', 'phlegm', 'blood', or 'lymph' further inflates the number of pathophysiological possibilities. In addition to producing illness when its quantitative balances or flows are disturbed, 'wind' is also unique among the *nyes pa* in its potential to increase and spread the pernicious influence of over-accumulations of any of these other psychophysiologic agents (i.e. 'bile', 'phlegm', 'blood', or 'yellow water') throughout the body.

> Given this (i.e. the preceding verse), 'wind' is the primary cause of the aggravation of all illnesses.
> It conveys various [diseases], it amasses [their] consequences, it disperses [them to different parts of the body], and it makes [them] encompass [the body].
> [Wind's] intrinsic nature being noxious, because it is rough,[14] [it causes] many diseases.[15]

Because psychic and communicative functions are understood to be essentially motile phenomena, the normality of the senses, affect, cognition and social conduct are all understood to depend on the physiologically proper deployment of 'wind'. Disturbances in any of those realms, the types of disorders which biomedicine would regard as psychiatric or neurological, are consequently classified as disruptions of 'wind'. (Nosological distinctions in the *Rgyud bzhi* are most often drawn along pathophysiological rather than symptomatological lines). Most 'wind' illnesses, however, are not predominantly psychiatric in nature. Judging from the symptoms which the *Four Treatises* give for the sixty-three syndromes classified as 'wind illnesses', the majority are primarily neuromuscular or musculoskeletal conditions. Although psychiatric features are listed for some of these, they are predominant in only six.[16]

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the 'upward flowing wind' (*gyen rgyu rlung*), the 'encompassing wind' (*khyab byed rlung*), the 'digestive wind' (*me mnyam rlung*) and the 'downward flowing wind' (*thur sel rlung*) (see also Jacobson 2000). These same plexi are important in Tibetan Buddhist yoga.

[14] According to the *Four Treatises* 'wind' has six essential characteristics: 'roughness' (*rtsub ba*), 'lightness' (*yang ba*), 'cold' (*grangs shing*), 'penetrating' (*bra ba*), 'hardness' (*sra shing*), and 'mobility' (*kha yo ba*).

[15] BSYB Vol. 3, Chap. 2, Lns. 5–7. *De la rlung ni nad kun 'khrug pa'i rgyu / sna 'dren mjug sdud 'thor dang khyab par byed / rang rgyud gdug cing nad mang rtsub pa'i phyir /*

[16] These six are illnesses of the coordinating centers for 'life holding wind', 'upward flowing wind', and 'encompassing wind', and illnesses of 'head wind' (*mgo rlung*), 'marrow wind' (*rkang pa rlung*), and 'heart wind' (*snying rlung*).

Classical Nosology

Gso ba rig pa does not separate psychiatry out as a special branch of medicine, but presents both psychiatric and somatic symptoms as essential to many of the illnesses it describes. This is characteristic of Tibetan medical thought which in general does not dichotomise mental and physical phenomena in the systematic way that Euro-American science has. For the most part the *Four Treatises* classify conditions which biomedicine would regard as 'psychiatric', i.e. those in which disturbances of cognition, affect, perception or behaviour are most prominent, into one of two broad divisions: i) those caused by disturbances of 'wind', or ii) those caused by any of several types of evil spirits. Judging from the lists of pathognomonic symptoms which the *Four Treatises* provide, the former are those which biomedical psychiatry would classify as affective or anxiety disorders. In contrast, the syndromes described in its chapters on possession and spirit attack are more severe, involving delusions, hallucinations and overtly bizarre behaviour and would probably be classified as psychotic. In the course of my own observations in clinics in Tibetan refugee areas of northern India this distinction between 'wind' and spirit illnesses was actively applied, and differentiated these same broad types of disorders. It also rationalized a division of therapeutic labor in which classical physicians known as amchi treated 'wind illnesses' that were uncomplicated by spirits, but refer cases complicated by spirit attack or possession to certain lamas who specialised in exorcism. The two etiologies are not exclusive, however, and chronic cases of mental illness are often attributed to a combination of disturbed 'wind' and malevolent spirits. For their own part, such patients often resort alternately to classical physicians for help with their 'wind' imbalance and to lama-exorcists to rid them of demons. Visits to psychiatrists to try 'allopathic' medications may also part of the cycle in some cases.

Whereas 'wind' is an elemental dynamic that operates according to consistent principles, spirits are volitional beings who can be motivated by revenge, anger and other negative affects. They are apt to attack humans who offend them (even unintentionally), stray into or pollute their territory (generally wilderness areas), or become unusually vulnerable due to some physical or psychological weakness. Indeed, by weakening the individual's cognitive and attentional powers, 'wind illnesses' of the psychiatric kind are major predisposing factors to demonic attack.

Among the 63 different kinds of illness attributed to malfunctions of 'wind', the *Rgyud bzhi* defines 'life-wind illness' as an excess of 'wind' in the 'life-wind centre' (*srog rlung gi 'khor lo*), a psychophysiological coordinating plexus normally located in the middle of the forehead. It regulates swallowing, breathing, salivation, sneezing and belching, and is also responsible for "clarifying the intellectual and sensory faculties, and supporting thought".[17] Here again we note the integration of physiological and psychological functions which biomedicine would segregate. The *Rgyud bzhi* lists the circumstantial causes and symptoms of 'life-wind illness' as follows:

> [As for illnesses of the] life sustaining [wind]: It being disturbed by a diet of rough [foods], fasting and excessive work, [or] blocking [or] pushing impulses [to defecate or urinate, one becomes] dizzy,
> The feelings[18] are unstable, it is difficult to draw in breath and one is unable to swallow.[19]

Although this verse includes neither the affective element of 'uncontrollable crying', nor the correlates of anxiety such as 'worrying', and 'excessive mental, physical, or verbal activity' which the *Rgyud bzhi* elsewhere lists among the circumstantial causes of 'wind illnesses' in general, the latter are understood by both amchi and lay Tibetans to also contribute to the occurrence of 'life-wind illness'. In lay parlance 'unhappy mind' (*sems mi skyid po*), glossed in English as 'depression', is often used to describe the profound sadness which is present in many cases of 'life-wind illness', and 'breathless fear' (*sngangs skrag*) for the similarly intense 'anxiety' which is also common in this syndrome.

LAY TERMINOLOGY AND UNDERSTANDING

Knowledge of the doctrines of the *Rgyud bzhi* is not confined to physicians and monks schooled in classical Tibetan literature. Simplified

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[17] BSYB Vol. 2, Chap. 5, l. 105: *blo dang dbang po gsal zhing sems 'dzin byed.*

[18] According to an amchi informant the Tibetan term *snying*, the primary meaning of which is 'heart', in this passage instead connotes 'emotions', the heart being especially related to emotions for Tibetans as well as Euro-Americans. *Snying 'phyo* ('wandering heart') therefore denotes affective instability.

[19] BSYB Vol. 3, Chap. 2, ll. 161–63: *srog rlung zas rtsub smyung dang drag shul las / shugs bkag btsir bas 'khrugs te mgo bo 'khor / snying 'phyos dbugs sdud dka' zhing mid mi thub.*

cognates of its terminology and theory are also common in the discourse of lay Tibetan refugees who are illiterate in the classical form of their mother tongue. My own observations at Tibetan medical clinics suggest that this diffusion takes place through the amchis' provision of truncated bits of the classical model when patients request an explanation for their illnesses. This is a particularly clear instance of the impact of classical medical models on local understandings of illness (Good and Delvicchio-Good 1992).

Ordinary parlance invokes 'wind' as an explanation for disturbances of thought, emotion and conduct in much the same way as classical theory does. "I have wind today" or "He has wind", generally indicate a temporary condition of moderate irritability or emotional lability due to some adverse circumstance. 'High wind' (*rlung mtho po*) may also indicate a transient, purely circumstantial hyperirritability—"His wind is high because of arguing with relatives"—or a more enduring constitutional predisposition, "He always has high wind". It is understood that 'wind' is increased by prolonged or intense emotional excitement, exhausting physical or intellectual work, exposure to bad weather or food, severe economic hardship, and by separation from or loss of family members: "Her wind is high from working too hard outside and getting cold". Lay explanations for recovery from such states also invoke 'wind': "This medicine reduces my wind". "I heard some good news, so my wind is less". "I had a good time with my relatives, so my wind is less". As is obvious from these examples, there is a distinct similarity (not to deny that there are also differences) between the Tibetan lay explanatory use of 'wind' and Western lay invocations of 'stress' and 'trauma' to explain states of emotional or cognitive disturbance, and even of illness. This reflects the previously noted parallel between the explanatory use of 'wind' in the *Rgyud bzhi* and the Western biomedical notion of 'stress'. Each establishes a credible explanatory link between certain kinds of circumstances and events, and the behavioural and physical dysfunctions which seem to accompany and follow on those events.

Srog rlung ('life-wind' pronounced '*sog lug*'), a colloquial abbreviation for 'life-wind illness', is the commonplace term for this condition among lay Tibetans. (In order to distinguish the two, in what follows *srog lung* will indicate the lay construction of this illness, and 'life-wind illness' the classical construction as presented in the *Rgyud bzhi*). In the course of my fieldwork in Darjeeling and Gangtok between 1992

and 1996, *srog rlung* was commonly used in lay speech. This may be because it is by far the most common diagnosis given by amchi to patients who present affective, cognitive or behavioral disturbances which are not as florid as to be attributed to spirit attack or possession. The attribution of *srog rlung* is somewhat stigmatising, however, and many who are said to have suffered from it will deny it. Yet some will admit so in trust, and even discuss their symptoms and ways of thinking about it. Such testimonies reveal a distinctly broader variety of symptoms than those which the *Rgyud bzhi* lists for this disorder. (Again, the classical list may have been intended to be pathognomonic rather than phenomenologically exhaustive). Symptoms cited as typical by the patients themselves include affective lability, cognitive disorientation, disturbances of heartbeat and breathing, and a variety of somatosensory dysphorias (e.g. muscular tension, paresthesias, and numbness). In my observation of amchi clinics, patients emphasised these somatosensory symptoms when presenting to the amchi, who generally regarded them as typical of 'life-wind illness'. Rather than limiting their concept of this illness to the relatively compact description given in the *Rgyud bzhi,* lay Tibetans and amchi alike adduced symptoms which are typical of *srog rlung* and 'wind illnesses' in general, and especially those which are typical of the latter in which psychiatric symptoms predominate.[20]

Case Studies

Case studies were conducted with 16 Tibetan refugees living in northern India who had been diagnosed and treated by amchi for illnesses in which disturbances of perception, cognition, affect or social conduct were prominent. Several of each subject's clinical sessions with their

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[20] The symptoms which the *Four Treatises* list for 'wind illnesses' in general are anger, aching in the back of the neck, chest and jaws, dry vomiting, and pain moving around the body. Those which it attributes to the six wind illnesses in which psychiatric symptoms predominate, include affective lability, mutism, fatigue, impaired memory, fainting, talking much, restlessness, frightened by angry or critical talk, insomnia, mind ensnared, distractibility, being inattentive to news, confusion, and mental agitation. Somatosensory symptoms for this group include difficult breathing, difficult swallowing, stammering, mouth is crooked, palpitations, fainting, upper body feels full, buzzing in ears, vomiting, falling down, dizziness, shaking, and distention in the upper body.

Table 1: Number of patients diagnosed by amchi with 'life-wind illness' who reported various types of somatic symptoms. The average number of somatic symptoms reported was 11 per patient [n=6].

Reduced appetite or eating, or weight loss	6
Autonomic:	
Dizziness	4
Difficulty breathing	3
Nausea	3
Coughing	2
Heart palpitations	2
Dry mouth	2
Sneezing	1
Sweating	1
Thirst	1
Psychomotor:	
Fatigue	5
Restlessness	3
Body feels uneasy	1
Difficulty swallowing	1
Movements are rapid	1
Shaking-trembling	1
Pain:	
Headache	4
Pain in upper back	3
Pain in other areas	4
Tension, localised or general	4
Heaviness/lightness:	
Body feels light	2
Body feels heavy	2
Heart feels light & "lifting up"	2
Head feels too light, then too heavy	1
Miscellaneous:	
Localised internal burning	2
"Electrical" sensations	1
Head feels big	1
Numbness, entire body	1
Stomach feels bloated	1

Each of these four attributed their affective pain to specific losses. This suggests that a somaticising style of clinical complaint may be characteristic of Tibetan refugees who suffer from *srog rlung*, but that at least some are conscious of an affective component to their suffering. If confirmed in a larger sample, this would parallel the preference for clinical

amchi were observed and recorded, including the amchi's diagnostic conclusions. Other data collected from the patients included life histories, illness histories, unprompted descriptions of symptoms, and their responses to selected portions of a standardised diagnostic interview, the 'Structured Clinical Interview for Diagnostic and Statistical Manual' (SCID) (Spitzer *et al.* 1992). The purpose of the latter was not to reduce Tibetan forms of mental illnesses to biomedical categories, but to provide qualified psychiatric diagnoses which would support a comparison between the ways in which the two medical gazes would see these cases.

The amchis explained some of these cases as disturbances of 'wind', and others as a combination of disturbed 'wind' and spirit attack. Affective and somatosensory symptoms were prominent in the former, and more severe disturbances of conduct, cognition and perception in the latter, as one would expect from the parallel construction of these two divisions in the *Rgyud bzhi*. Six of the case study patients were diagnosed as suffering from 'life-wind illness': five women ranging in age from late twenties to sixties, and one man in his sixties. Each of these reported a wider range of symptoms than the *Rgyud bzhi* gives for this disorder. Evaluated against the criteria of the fourth edition of the 'Diagnostic and Statistical Manual of Mental Disorders for DSM-IV' (APA 1994), five of the six cases qualified for both major depression (MD) and general anxiety disorder (GAD), or missed full comorbidity by only a single criterion symptom. None of the six closely approached qualifying for any other DSM-IV diagnosis.

There was a high proportion of somatosensory complaints, many of which do not appear in the DSM-IV criteria for either MD or GAD (Table 1).[21] When presenting their illness to their amchi these subjects also accorded somatic symptoms a greater prominence than the dysphoric affects which biomedical psychiatry takes as more definitive of depressive and anxiety disorders. However, in longer interviews outside the clinic three of these patients described themselves as pervasively sad, and the fourth suffered from 'agitated mind'.

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[21] Some investigators have found that somatic symptoms are more prevalent in depressive and anxiety disorders than the DSM criteria suggest (Katon 1982, 1984). Other research has suggested that they are also more prevalent in depressed Asian refugee populations (Farooq *et al.* 1995, Hsu 1999, Kroll *et al.* 1988, Lin *et al.* 1985).

somaticising by neurasthenia patients in Taiwan and China (Kleinman 1982, 1986), and also a tendency in some Asian societies to emphasize somatic complaints when presenting depression-anxiety spectrum illnesses (Faroq *et al.* 1995, Hsu 1999, Lin *et al.* 1985, Tseng 1990).

Although this sample is far too small for statistical significance, it suggests that the closest DSM equivalent for *srog rlung* may be 'highly somaticised comorbid depression and generalised anxiety'.[22] This is not meant to force this distinctively Tibetan illness into the procrustean bed of the DSM, but rather to locate it roughly on that nosological map. This tentative finding places *srog rlung* in the company of similar syndromes of highly somaticised, comorbid anxiety and depression which have been described in several other cultural settings.[23]

TIBETAN PANIC ATTACK

Four of the six life-wind subjects also reported episodes of acute panic which occurred repeatedly over periods of many months.[24] These experiences were distinguished from more chronic aspects of *srog rlung* by the rapidity of their onset, a marked intensification of fear and somatosensory dysphorias, and their time limited nature. Neither clas-

[22] Significant rates of comorbidity between the MD and GAD are found in the United States, as well as of depressive and anxious disorders in general (Ballenger 1998, Pasnau and Bystritsky 1994, Roth *et al.* 1972, Van Valkenburg *et al.* 1984, Wittchen *et al.* 1994). This underlines the relevance for transcultural psychiatry of the proposed category of 'mixed anxiety and depression', even though its advocates intend it for cases of comorbid anxiety and depression which are subcriterial (Guarnaccia 1997: 13–14, Katon and Roy-Byrne 1991, Sartorius and Ustan 1995, Zinbarg *et al.* 1994). The prevalence of comorbidity for fully qualified rather than subcriterial MD and GAD in my small sample reflects the fact that Tibetan refugees presenting themselves for treatment are generally far more depressed and/or anxious than patients who are identified as suffering from the same types of disorders in the United States. Tibetan refugee culture seems to require a higher threshold of severity for symptoms of these kinds before attributing them to an illness worthy of a clinical visit. Syndromes of depression and/ or anxiety which would fail DSM criteria seem to be generally regarded as insufficient to warrant medical treatment.

[23] These include 'heart distress' in Iran (Good 1977, Good and Delvicchio-Good 1982), neurasthenia in Taiwan and the People's Republic of China (Kleinman 1982, 1986; Lee 1998) and in Europe and the United States (Rabinbach 1992), *susto* (Rubel *et al.* 1984) and other forms of *nervios* in Latin American societies. In a crosscultural review of disorders of 'nerves' Low (1985) identifies several other culturally contextualised syndromes with similar symptomatologies.

[24] Thanks to Devon Hinton for encouraging a secondary analysis of this data under the rubric of panic illness.

sical nosology nor colloquial Tibetan parlance reserve a term exclusively for such episodes. Patients and amchi alike regarded them simply as transient intensifications of chronic 'life-wind illnesses'. Just as it does for many other types of psychiatric illnesses as well, Tibetan medicine recognises that such episodes may also be caused by spirit attack. One of the four subjects who reported episodes of panic was diagnosed by her amchi to be suffering from a combination of severe "life-wind illness" and spirit attack.

Table 2: Number of 'life wind' patients who reported various types of symptoms as typical of brief episodes of acute anxiety. Each of these patient's episodes approximated DSM-IV criteria for Panic Attack. The average number of symptoms reported was 10 per patient [n=4].

Affective	
Fear of imminent death	3
Fear of "going insane"	2
Fear of "floating away"	1
Irritation	1
Cognitive	
Difficulty concentrating	3
Difficult or impossible to think	1
Impaired recall of general knowledge	1
Mental agitation	1
Amnesia for day of attack	1
Obsessive impulse to 'go out at night'	1
Dissociative	
Derealization and depersonalisation	1
Psychomotor	
Fatigue due to difficult breathing	2
Sensory	
Dizziness and faintness	3
Palpitations	3
Shortness of breath	3
Back pain	2
Chest pain	2
Abdominal pressure-pain	2
Paresthesias	2
Impaired vision ("dust in my eyes")	1
Body feels too light	1
Body feels too hot	1
Choking sensation	1
Headache	1

The episodes they described met all but one of the DSM-IV criteria for Panic Attack including 'a discrete period of intense fear or discomfort', 'sudden onset', severe disturbance of somatosensation and/or cognition, individually stereotypic focus of apprehension on particular somatic sensations of distress (most often respiratory or cardiac) or cognitive dysfunction, stereotypic interpretation of such sensations as boding either imminent death or insanity, experienced lack of control over these symptoms, and relatively brief duration of the symptoms (APA 1994: 394–95).

Table 2 lists the symptoms of acute episodic anxiety which these individuals reported. Many were aggravations of somatosensory dysphorias or cognitive dysfunctions which in more attenuated form were typical of their chronic *srog rlung*.[25] The DSM-IV requirement that onset builds to a peak in ten minutes or less was difficult to evaluate objectively, but it was my impression from these patients' accounts that onset was typically longer for them. This may be regarded as a significant point of cultural variation in symptomatology, or it may be cited as a reason to classify these episodes as anxiety attacks rather than panic attacks.[26]

In addition to an apparently slower rate of onset, the Tibetan attacks also varied from DSM criteria in the number, range and prominence of somatosensory dysphorias, and in an absence of attempts to flee the locale of the attack. However, none of these characteristics disqualified them from DSM Panic Attack. As Table 2 shows, the four subjects together reported a total of 27 somatosensory symptoms for these attacks, for an average of 6.75 per case.[27] Despite this, none met DSM-IV criteria for somatisation disorder. The wide range of their somatosensory symptoms was also significant. Each of the four reported some which do not appear in the DSM-IV criteria.[28] These included for one man a burning pain that moved about the front and back of his rib cage, for one of the women a burning sensation in her stomach, and

[25] The tabulation given here includes only symptoms which occurred exclusively or markedly intensified during the attacks. Those which were chronically part of the underlying 'life-wind illness' and did not intensify during attacks are not listed.

[26] Thanks to David Healy for bringing this argument to my attention.

[27] Despite the DSM-IV requirement of only four somatosensory symptoms in its criteria for Panic Attack, some research suggests that even in the United States the average Panic Disorder patient may suffer from a greater number (Cox *et al.* 1994: 352).

[28] Katon (1984) noted that panic attack patients in the United States commonly report somatic symptoms which are not included in the DSM criteria.

for another woman an already mentioned hallucination that her body was becoming so alarmingly light that she feared floating away. The absence of a desire to flee the locale of their attacks may have been because the episodes most often occurred late at night when they were at home trying to sleep, and being at home seemed safer than going outside. ('Going out in the night' is understood to be a dangerous invitation to spirit attack. In fact, according to an amchi informant, the obsessive impulse to leave their home and wander in the night is induced by a spirit who wants to attack that particular individual).

Despite these disparities the episodes described by each of the four subjects satisfied all except the ten minute onset criterion for DSM-IV Panic Attack. They are, therefore, preliminary evidence of a Tibetan form of panic illness which takes its place among other variants of panic illness which have been found in other cultural settings.[29] Three additional points of comparison strengthen the case for this conclusion. i) As in some other cultural variants of panic illness, my Tibetan subjects reported that the frequency of their attacks waxed and waned in concert with fluctuations in the severity of their more chronic, underlying psychiatric illness.[30] ii) The foci of their panics were congruent with findings in the United States and Great Britain. Of the four cases, three panicked at sensations of cardiorespiratory disturbance, the same focus found to be most common in American and British subjects. The third had episodes in which her body felt rapidly lighter, which made her panic at the prospect of floating up into the air. This was highly unusual from a Euro-American perspective, but still fell within the DSM-IV provision for 'other forms of ego-loss'.[31] iii) Although we did not search for cases of panic illness in individuals without a diagnosis of 'life-wind illness', the coincidence of such episodes with that depressive-anxious syndrome in these four cases is consistent with findings of

[29] The Cross-National Collaborative Panic Study (Buller *et al.* 1992) found significant numbers of subjects who met a modified DSM-III criteria for Panic Disorder in 14 countries which as a group spanned four cultural areas. In their discussion of the same data Amering and Katschnig (1990) noted a high overlap of symptoms between DSM-III defined Panic Attack, *koro* in Southeast Asia (Bernstein and Gaw 1990) and *kayak-angst* in Greenland and Polar Eskimo society (Carr 1978). Other studies of culturally contextualized panic illnesses include Hinton *et al.* 2000, Lewis-Fernandez *et al.* 2002, Park and Hinton 2002, and Hagengimana *et al.* 2003.

[30] Amering and Katschnig (1990) reported that 24% of studies of panic disorder in various cultural settings which they reviewed found courses of alternating remission and relapse to be typical.

[31] The names given here are pseudonyms.

40 to 65% rates of comorbidity between PA, GAD and MD in the U.S. and Great Britain (Briggs *et al.* 1993; Wittchen *et al.* 1994).[32]

The coincidence of the hallmark features of Panic Attack with significant departures from DSM criteria argues, as do Hinton's similar findings for Khmer panic illness (Hinton *et al.* 2000), that if those criteria are to adequately detect panic attack across cultures, they must be revised to include a wider range of symptomatic variation, especially with respect to somatosensory and temporal parameters.

Distressing Life Events as Etiological Factors

In their illness histories the six subjects who had been diagnosed with 'life-wind illness' cited various types of distressing events as having triggered long periods of worsened chronic symptoms and more frequent panic attacks (Table 3). Many of these varieties of suffering are accommodated by implication in the inclusion of 'uncontrollable crying' and 'worrying' as circumstantial causes of 'wind illnesses' in the *Rgyud bzhi* in general. One subject's *srog rlung* began when he learned of the death of his eight year old son. Another's began when, having already lost two of her children to illnesses, she learned of another daughter's death. Another's began when her husband was robbed of his entire stock-in-trade by Chinese troops, and her 'life-wind illness' became more severe when he subsequently fell ill and then died. The fourth subject's illness began when her daughter's decision to leave home for training at a remote school triggered an agitated depression which then worsened dramatically when a neighborhood friend unexpectedly passed away.

The stressors which these individuals cited as having provoked their *srog rlung* are congruent with research in the United States and Great Britain which has found similar events to be the most common antecedents to both depression and panic attack. These include separation from spouse or family, the death of a family member or close friend, difficulty at work and loss of employment, loss of material possessions, loss of physical health, and loss of a cherished ideal (Brown *et al.* 1987, Eifert and Forsyth 1996, Jacobs *et al.* 1990, Katon 1984).

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[32] In a review of data on the comorbidity of Major Depression and Panic Disorder drawn from the National Comorbidity Survey and the WHO Primary Case Study, Ballenger (1998) concluded that the high prevalence of this comorbidity is 'one of the strongest psychiatric associations'.

Table 3: Number of patients reporting various types of distressing events as contributing to periods of aggravated 'life-wind' and increased frequency of panic attack. The totals here do not reflect the fact that some subjects experienced some types of events multiple times. Taking that into account, the average number of such events reported was 5.5 per subject (n=4).

Flight from Tibet and refugee relocation	4
Financial	
Anxiety about family finances	3
Loss of family capital	2
Death, illness and separation	
Death of a child	2
Separation from a child	2
Death of a spouse	2
Prolonged illness of a spouse	2
Absence of care by relatives	2
Death of a parent	1
Permanent separation from a spouse	1
Death of a sibling or other relative	1
Death of a neighbor	1
Personal illness or injury	
Major physical illness	2
Major physical injury	1
Other	
Capture by Chinese military	1
Extensive combat experience	1
Jailed	1

Many of these events were occasioned by the Chinese annexation of Tibet. Each of the six case study subjects had experienced a brutal military occupation in which the violent death or forced separation of family members, friends and neighbours were consequences. Some years later, as refugees in India, they had learned of the wholesale destruction of Tibetan monasteries by the Red Guard during Mao's Cultural Revolution, a second collective cultural tragedy which must be counted as among the most painful of their losses. These grim developments surely contributed to their collective psychosomatic suffering, and hence to the predisposition of the more psychiatrically vulnerable among them to anxious and depressive illnesses. Studies of psychiatric morbidity in other populations of Asian refugees have found elevated rates of depressive and anxious disorders with high incidences of

somatic symptomatology (Carlson and Rosser-Hogan 1991, Eisenbruch 1991, Hinton *et al.* 2000, Kroll *et al.* 1988, Lin *et al.* 1985).[33]

Conclusion

This chapter has combined findings from the study of the *Rgyud bzhi*, anthropological fieldwork with contemporary amchi and their patients, and psychiatric studies in other cultural settings. The reflection of these three perspectives on one another enriches our appreciation of the complex interaction of cultural, social, and pan-cultural factors in such conditions. The comparison of classical Tibetan and modern psychiatric constructions of Tibetan refugee cases does not necessitate a reduction of the phenomenology of 'life-wind illness' as professionally understood by amchi, nor of *srog rlung* as constructed by lay Tibetans, to biomedical terms. The location of these closely related, distinctively Tibetan forms of distress within the standardised, if imperfect, nosology of DSM does, however, facilitate a comparison of their etiologies, symptomatologies, and courses with those of disorders in other cultural settings which have been found to approximate the same DSM criteria.

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[33] Kroll *et al.* (1988) proposed that in refugee populations beset by the daunting combination of loss, trauma and difficult adaptation to unfamiliar circumstances, the combination of somaticised depression, anxiety, and post-traumatic stress disorder (which are separate diagnostic categories in the DSMs) converge into a syndrome of collective bereavement which deserves its own nomenclature.

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TIBETAN MEDICINE AND THE CLASSIFICATION AND TREATMENT OF MENTAL ILLNESS

COLIN MILLARD

INTRODUCTION

This chapter is about mental illness[1] in Tibetan medicine, its classification, diagnosis, and treatment. The discussion will be based on research carried out in clinics of Tibetan medicine in Nepal and the UK It will address the major debate in transcultural psychiatric studies about whether certain features of psychiatric experience can be said to be universal, or whether representations of mental illness are entirely framed by the culture in which they occur. In what follows, a comparative assessment will be made of Tibetan medical approaches to mental disorders in a South Asian context and in Tibetan medical clinics in the UK A further layer of comparison will be between Tibetan approaches to mental disorder and those of Western psychiatry.

The Tibetan language has a wealth of words that denote various states of mental disorders, from mild disturbance to full blown psychosis. The general term for mental illness found in the *Rgyud bzhi*[2] or used by Tibetan doctors is simply 'sickness of the mind' (*sems nad* or *sems skyon*). If one wants to relate the two widely used categories of Western psychiatry, i.e. neurotic and psychotic states, with Tibetan concepts, then 'neurotic states' would best correspond with Tibetan words conveying 'depression' (*skyo snang, sems pham pa, sems sdug*), 'anxiety' (*sems ngal, sems 'tshab pa, sems khrel*), or 'panic' (*'jig skrag zhad snang, dngangs skrag*); and 'psychotic states' are conveyed by various

[1] This chapter follows Eisenberg's (1977) distinction between 'disease' as the pathological condition based in the human body, and 'illness' as an individual's perception of a socially disvalued condition. As equivalents of the latter, I have also used the words 'sickness' and 'disorder' in this chapter. As the physiological basis of mental disorders in many instances remains problematic I have generally avoided the term 'disease'.

[2] Throughout this chapter I have used the 1992 Lhasa edition of *Bdud rtsi snying po yan lag brgyad pa gsang ba man ngag gi rgyud* (see bibliography).

terms denoting 'madness' (*smyo nad, sems rnyog khra, sems skyon nad rigs*).

Before proceeding to discuss Tibetan medical and Western psychiatric principles and practice, I will begin by briefly discussing the two fieldwork locations that the discussion in this paper draws upon. Between September 1996 and August 1998 I conducted fieldwork in a Tibetan medical school situated in the valley of Dhorpatan in the Baglung district of west Nepal. The school includes a classroom, a clinic, and a pharmacy where locally gathered plants and raw medicinal substances brought from outside the valley are processed into medicines. The teacher in the medical school is Tsultrim Sangye (usually referred to as Amchi Gege), a Bon po[3] monk and Tibetan medical doctor trained in Tibet, who founded the school in 1990. At the time of the research he was 60 years old. There were ten medical students at the school. The research focused on learning processes in the classroom, clinic and the pharmacy: how Tibetan medical knowledge was constructed in these arenas; and how the students were inducted into the Tibetan Bon medical view.[4] Living in the valley of Dhorpatan, at the time of my fieldwork, there were about 250 Tibetan refugees and around a thousand Nepalese representing seven ethnic groups. The clinic was used by both Tibetans and Nepalese. In this article, I will focus on the diagnosis and treatment of mental illness in the clinic.

The second fieldwork location concerns the clinics of the Tara Institute of Tibetan medicine in the UK The Tara Institute of Tibetan Medicine is part of Tara Rokpa Edinburgh, a charitable organisation set up by Akong Rinpoche, a Tibetan Buddhist lama and doctor of Tibetan medicine, who along with Chogyam Trungpa Rinpoche founded Kagyu Samye Ling Tibetan Centre at Eskdalemuir in Scotland in 1967. Tara Rokpa Edinburgh is concerned with the healing arts, both in terms of psychotherapy and medicine. The Tara Institute of Tibetan Medicine has a number of aims: to establish Tibetan medical practice in the West,

[3] According to its practitioners, known as Bon po, Bon is the pre-Buddhist religion of Tibet. In terms of knowledge and practice it has much in common with the four main Tibetan Buddhist schools. For further information on the Bon religion see Karmay 1975 and Kværne 1972, 1995.

[4] For the results of this research see Millard 2002. Part of the reason why I chose this location is because the main medical text that is used in the school is the Bon medical text called *'Bum bzhi*. It became quickly evident, however, that the *'Bum bzhi* and the main Buddhist medical text, the *Rgyud bzhi* are, with the exception of material on history and lineage, almost identical.

to set up a training programme in Tibetan medicine and to undertake scientific studies to establish the safety, efficacy and cost effectiveness of using Tibetan medicines. The Tara Institute runs clinics of Tibetan medicine each Wednesday in a complementary health centre in Edinburgh and once a month in Glasgow, London, and the Kagyu Samye Ling Tibetan Centre at Eskdalemuir in Dumfriesshire, and up until recently, once a month in Dundee. At present all the medicines that are used in the clinics in the UK are manufactured in a Tibetan medical hospital at Si ling (Xining) in east Tibet. The Tibetan doctor who practises in the Tara clinics, Lobsang Dhonden, is a graduate of the Lhasa Medical College in Tibet. I began to work with him in October 2002, with the task of facilitating communication between him and his English speaking patients in the clinics and building up a database of what happened in the clinical interactions, to provide data for the research aims set up by the Tara Institute.

THE APPROACH TO MENTAL ILLNESS IN THE TARA CLINICS IN THE UK

Between October 2002 and June 2004 I collected data on 585 clinical interactions in the clinics of the Tara Institute of Tibetan Medicine. Here, I will focus on a number of these clinical interactions that involve mental illness. Table 1 gives the amount of patients who came to each clinic whose range of conditions can be classified under 'mental illness'.

By 'mental illness' here, I mean that the patients complained of some specific mental problems, such as depression, anxiety, or panic attacks; this may have been accompanied by other physical symptoms, or on its own. Some patients came only once to see Dr. Dhonden, others returned on numerous occasions. Usually patients are given medicine to last for one month and are asked to come back so that the doctor can check how they have responded to the treatment. When the patient arrived, first Dr. Dhonden would listen to what she/he had to say about her/his condition, occasionally asking questions for clarification, and then he would take the patient's, pulse usually asking further questions related to his pulse reading.[5] Some patients had already received

[5] The pulse is taken at three locations on the radial artery with the index finger, middle finger, and the ring finger. Each finger takes two pulses, thus totalling twelve pulses. Pulse diagnosis is covered in the first chapter of the fourth *tantra* of the *Rgyud*

a biomedical diagnosis, and were taking biomedical medications, and others had not. In what follows, I will discuss the clinical interactions that occurred with ten of these patients, with the aim of illuminating similarities and differences between the approaches taken in Western psychiatry and in Tibetan medicine.

I have divided the patients who came to the Tara clinics with a mental illness into three categories. The first group comprises of patients who came with mild symptoms such as: stress, difficulty sleeping, poor concentration, and so on (patients 1 to 3). The second group includes those patients with more severe symptoms, such as anxiety, panic attacks and depression (patients 4 to 8). The third group consists of those patients with very severe mental disturbances, what Western psychiatry would refer to as 'psychosis' (patients 9 and 10). It should be noted that it is quite common in the Tara clinics for patients to have a range of disorders, on both a psychological and physiological level, speaking from a Western point of view. As such each patient is unique and the medicines that Dr. Dhonden gives are adapted to his assessment of the individual's specific medical requirements. We will also see that these requirements are not static but change throughout the course of the illness. Another important point to mention here is that the medicines that are used in the Tara clinics have been adapted to conform to existing legal requirements on the use of herbal medicines in the UK.[6] Traditionally, the principal medicinal compounds used for mental dis-

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bzhi. In Tibetan medicine all illnesses can be divided into those that are considered to have a hot nature and those that are classed as cold. The pulse chapter gives 12 general pulses, six for hot disorders and six for cold. The six hot pulses are: 'strong' (*drag pa*), 'prominent' (*'bur*), 'fast' (*mgyogs pa*), 'twisting' (*'dril ba*), 'hard' (*mkhrangs pa*), and 'taut' (*grims pa*). The six cold pulses are: 'weak' (*zhan*), 'deep' (*bying*), 'impaired' (*gud*), 'slow' (*dal po*), 'loose' (*lhod*), and 'empty' (*stong*). The chapter then goes on to describe the specific pulses of 46 different kinds of disorders. Two pulses that are not in this list which, however, appear in the following accounts are 'expanded' (*rgyas*) and 'thin' (*phra*). According to Tibetan medical theory, underlying all psychological and physiological processes are the three *nyes pa*, a Tibetan term which following Galenic medicine is usually translated as 'humour', but actually means 'fault'. The three humours are 'wind' (*rlung*), 'bile' (*mkhris pa*) and 'phlegm' (*bad kan*). With mental disorders the pulse will often display the qualities of a wind imbalance, 'empty' (*stong*) and 'floating' (*rkyal*), though sometimes one or both of the other two humours can predominate. See Meyer 1990 for a translation of the pulse chapter.

6 Minerals and animal products are prohibited in herbal medicines in the UK and are not used in the medicinal compounds in the Tara clinics. In addition, no plants are used which are restricted or illegal according to the regulations of the Medicines and Healthcare Products Regulatory Agency. For a discussion on the law relating to herbal medicines in Europe and the UK see Millard 2007.

orders in Tibetan medicine, in particular those affecting the 'life supporting wind' (*srog rlung*),[7] are various medicinal compounds having *Aquilaria agallocha* (*a ga ru* or *a gar*) or Eagle wood as their principal ingredient.[8] As these medicinal compounds contain minerals, in the Tara clinics plant substitutes are used accordingly.

Table 1: Case Studies

Clinic	Period Covered	Period Duration	Total Male Patients	Total Female Patients	Total Patients	Number of Patients with mental Disorders
Edinburgh	23/10/02 to 18/5/04	19 months	29	50	79	13 (16%)
Samye Ling	9/11/02 to 8/2/04	16 months	29	43	72	21 (29%)
Glasgow	1/1/02 to 11/6/04	20 months	9	15	24	7 (29%)
Dundee	2/11/02 to 7/6/03	8 months	4	6	10	2 (20%)
London	25/10/02 to 17/5/04	20 months	24	69	92	13 (14%)

Patient 1

This 30 year old male patient came to the clinic two times. I was not present when he visited the first time. He had come to the clinic for treatment of stress. He explained that he had been trying to reduce his stress levels by lifestyle changes as Dr. Dhonden previously had suggested. He had now taken up relaxation classes and was feeling a little better. Dr. Dhonden asked him if he had been sleeping well, to which he replied yes. His pulse was, 'prominent', 'empty' and 'slow'. Dr. Dhonden concluded from the symptoms and his pulse reading that the patient was suffering from *rlung khams 'khrug pa*, 'a disturbance in the wind humour'. He was given three medicinal compounds for one month: *skyer khan lnga pa* to be taken in the morning; *lcam 'bras lnga*

[7] *Srog rlung* is the name given to various forms of mental illnesses caused by a disturbance in the 'life supporting wind' (*srog 'dzin rlung*) in the heart centre. This will be explained in detail later in this paper.

[8] Epstein and Rabgay 1982 list all the ingredients for four *a gar* based medicinal compounds.

pa, to be taken at lunchtime; and *seng ldeng brgyas pa* to be taken with his evening meal. The patient did not come back again to the clinic.

Patient 2

This was a 36 year old female patient. She came to the clinic only once. She complained of low energy, stress and anxiety. She thought it was partly related to her marriage having recently broken up. Her pulse was, 'expanded' and 'empty'. Dr. Dhonden diagnosed her condition as a wind imbalance causing what he referred to as *lus zungs 'khrug pa*, 'a disturbance in the body's energy'. He gave her three medicines for one month: *byis pa'i tshad thang*, to be taken in the morning; *'o la se lnga pa*, to be taken at lunch time; and *gnyan po bdun pa* to be taken with her evening meal.

Patient 3

This was a 35 year old female patient. She said that her main problem was that she could not sleep. She was also feeling stressed. Dr. Dhonden asked her whether she was having any emotional problems, to which she replied no. Then he asked her if she had any tension around the back of her neck,[9] she replied yes and added that sometimes she got wind in her stomach and when this happened she felt it was bloated. Her pulse was 'thin' and 'slow'. Dr. Dhonden diagnosed her condition as a 'slight disturbance in the wind humour'. She was given three medicines for one month: *se 'bru lnga pa*, to be taken in the morning; *bre ga lnga pa*, to be taken at lunch time; and *bdud rtsi lnga pa* to be taken with her evening meal.

Patient 4

This was a 42 year old female patient. She came to the clinic once. She had suffered from Myalgic Encephalitis (M.E.) for four years but was now much better. She still got tired very easily and her mind was not clear. She wanted to try and get back to living a normal life. Her pulse was 'weak'. During his time working in the Tara clinics Dr. Dhonden had seen numerous patients with M.E. In his opinion this disorder was due to 'a disturbance in the wind humour affecting the central nervous

[9] This is a symptom of a *rlung* disorder.

system'.[10] He gave her three medicines for one month: *gso byed nyi dkyil*, to be taken in the morning; *bre ga lnga pa*, to be taken at lunch time; and *nor bu bdun thang* to be taken with her evening meal.

Patient 5

This 44 year old female patient came to the clinic three times. On her first visit she explained that she had just come back to the city after spending three months in the countryside. She had found the transition back to city life very difficult and she was having problems sleeping and she had been getting headaches all the time. She added that she had been suffering for some time with irritable bowel syndrome. Her pulse was 'empty' and 'weak'. Dr. Dhonden diagnosed a mild form of *srog rlung*. He gave here three medicines for one month: *ma nu bzhi thang*, to be taken in the morning; *'o la se lnga pa*, to be taken at lunch time; and *snya lo lnga pa* to be taken with her evening meal.

On her second visit one month later, she said that in the first half of the month she had been feeling very stressed and her body and mind had felt slow and sluggish. She had also had pains in the region of her heart and the insomnia had persisted. In the third week her energy had increased but this had been accompanied by a feeling of herself and the world being 'insubstantial'. In the fourth week her energy had gotten much better and the pain had gone. Her pulse was again 'empty' and 'weak' but less so than on the previous occasion, it was also now 'prominent'. Dr. Dhonden gave her two different medicines: *byis pa'i tshad thang*, to be taken in the morning; *'o la se lnga pa*, to be taken at lunch time; and *snya lo lnga pa* to be taken with her evening meal.

On her third visit, the following month, she said that although during the month she had felt some fear and agitation, and had experienced some difficulty sleeping, she was now feeling the best she had felt for years. Dr. Dhonden told me that her pulse was still 'prominent', 'empty' and 'weak', but much improved on what it had been on her first visit. He gave her another month of the same medicines.

[10] Throughout the history of this disorder, identifying its exact nature has proved problematic in biomedicine. Originally, it was thought to be caused by infection of the brain, hence the name Myalgic Encephalitis (M.E.). In 1988, due to lack of evidence of viral causation it was renamed Chronic Fatigue Syndrome. Dr. Dhonden had no problem understanding this disorder in terms of a disturbance in rlung. The history of the changing perceptions of this disorder in biomedicine has been documented by Aronowitz 1991.

Patient 6

This 32 year old female patient came to the clinic on one occasion. She said that she had two problems: the first was anxiety, and 'shaky nerves'; and the second was a large lump under her shoulder blade. She thought that Tibetan medicine could dissolve the lump. Dr. Dhonden said that this was possible but it could take a long time. He asked her if her parents had respiratory problems, she replied no. He asked this because in Tibetan medicine lumps of this nature can be related to respiratory disorders. Her pulse was 'slow' and 'empty'. Dr. Dhonden diagnosed the patient's mental condition as a mild form of *srog rlung*. He gave her three medicines for one month: *skyer khan lgna pa*, to be taken in the morning; *sga sbyong gsum pa*, to be taken at lunch time; and *bdud rtsi lnga pa* to be taken with her evening meal.

Patient 7

This was a 25 year old male patient. He came to the clinic on one occasion. He explained that for a few years he had not been sleeping well and consequently he was constantly tired. He had very poor concentration and his mind was often 'foggy' resulting in having problems to remember things. Dr. Dhonden took his pulse and asked him if he had any problems with his gall bladder or liver, to which he replied no. Then Dr. Dhonden asked him if he had any problems with his joints. He replied only with his knees after he had been running. His pulse was 'empty' and 'weak'. Dr. Dhonden diagnosed the patient as suffering from a mild form of *srog rlung*. He was given three medicines for one month: *bdud rtsi gsum sbyor*, to be taken in the morning; *hong len drug pa*, to be taken at lunch time; and a *sho lnga pa* to be taken with his evening meal.

Patient 8

This 26 year old male patient came to the clinic on three occasions. He had just completed a PhD and for some time he had been experiencing high levels of stress. He said that generally in the mornings he had low energy and panic attacks, and in the evenings he felt agitated and anxious. Doctor Dhonden asked him if he had any pains around the top of his back, to which he replied no. He then asked him if he had any problems with his digestion. The patient told him that he went through peri-

ods when he didn't go to the toilet for days, then this would be followed by a few days of diarrhoea. His pulse was 'prominent' and 'twisting'. Dr. Dhonden diagnosed a form of mild *srog rlung*. He gave him three medicines for one month: *bde skyid lnga pa*, to be taken in the morning; *bre ga lnga pa*, to be taken at lunch time; and a *bdud rtsi lnga pa* to be taken with his evening meal.

On his second visit to the clinic, one month after, he said that his condition had improved a little though he was still getting panic attacks. Dr. Dhonden asked him if he had had any headaches; he replied no, but he had experienced a pressure in his head. Then Dr. Dhonden asked him about his stomach, to which he replied that it felt 'tense'. This time his pulse was 'prominent', 'weak' and 'slow'. He was given two new medicines: *se 'bru lnga pa*, to be taken in the morning; *bre ga lnga pa*, to be taken at lunch time; and a *skyer khan bzhi pa* to be taken with his evening meal.

On the following visit to the clinic, again one month after, he said that he was feeling much better. His only problem was that he had been feeling very tired, and that he had been sleeping for long periods of time. His pulse was still 'prominent' and a little 'slow' but much better than it had been in previous months. He was given three medicines for one month: *khrag 'khrug bdun pa*, to be taken in the morning; the same lunch medicine, *bre ga lnga pa*; and *bdud rtsi lnga pa* to be taken with his evening meal.

Patient 9

This was a 26 year old male patient. He had consulted with Dr. Dhonden on several occasions before I started working in the clinics. Most often he came to the clinic with his mother. He had suffered from mental illness for many years and had been prescribed anti-psychotic drugs. On the first consultation that I recorded, his mother did most of the talking. She said that he had still been depressed. He also had what she referred to as 'boils' on the top of his head. She said that his body was stiff and he couldn't do any exercise. Dr. Dhonden asked the patient whether he got headaches or if he had had any problems with his stomach, to which he replied no. Dr. Dhonden then asked him whether he was still taking the anti-psychotics drugs, at which point his mother answered that he always takes them otherwise he gets depressed. His pulse was 'thin', 'slow', 'prominent', and 'weak'. Dr. Dhonden told me

that the illness was *srog rlung*. He gave him three medicines for one month: *se 'bru lnga pa*, to be taken in the morning; *sa 'bru pad ma 'dab brgyad*, to be taken at lunch time; and *hong len lnga pa* to be taken with his evening meal.

On his next visit, three months later, he came alone. He said that he was still getting 'boils' on the top of his head. He added that sometimes he felt like blood was rising at the back of his neck and this was accompanied by a pulsating sensation; this usually occurred when he travelled on the bus. His pulse was a little 'slow' and 'prominent'. The doctor said to him that his pulse was much better and asked him if he felt mentally more composed, to which he replied yes. The doctor also asked him if he had had any pains in his upper back to which the patient replied that he had not. Dr. Dhonden gave him three new medicines for one month: *bsil chab bzhi pa*, to be taken in the morning; *mdzo mo bzhi thang*, to be taken at lunch time; and *skyer khan lgna pa* to be taken with his evening meal.

His next visit was six months later. Again he came alone. He said that he had been feeling reasonably well, but that he had recently had a cold. His pulse was again a little 'slow' and 'prominent'. Dr. Dhonden gave him three medicines appropriate for the new condition: *bsil chab bzhi pa*, to be taken in the morning; *ba lu lnga pa*, to be taken at lunch time; and *seng ldeng brgyad pa* to be taken with his evening meal. His next visit was two months later, and this time his mother came with him. He said that he had been experiencing much pain at the back of his head, especially when he travelled on the bus. The doctor again asked him whether he was still taking his Western medicine. His mother replied that he needs to take it otherwise he loses control of himself and as she put it, he will end up 'running into the river'. His pulse was now 'prominent', 'smooth' and 'slow'. Doctor Dhonden asked him if he had had any problems with blood pressure, to which he replied no. Again his medicines where changed to respond to the new condition. He was given: *khrag 'khrug bdun pa*, to be taken in the morning; *ba lu lnga pa*, to be taken at lunch time; and *bdud rtsi lnga pa* to be taken with his evening meal. Dr. Dhonden stipulated that he should not take the Tibetan medicine and the biomedical drugs at the same time, and there should be a gap of at least 30 minutes.[11]

[11] In most cases Dr. Dhonden thought that there was no problem taking biomedical drugs and Tibetan medicine together. Dr. Dhonden advised against patients taking Tibetan

Patient 10

This was a 49 year old female patient. She referred to herself as schizophrenic and had been taking anti-psychotic drugs for many years. She had seen Dr. Dhonden almost every month for about a year before I started to work with him. She kept an intricate journal which documented both her dreams and her experiences in everyday life. When she came to the clinic she would spend up to thirty minutes reading extracts from her new entries in this journal to Dr. Dhonden. I attended six of her consultations. Dr. Dhonden said that her condition was *srog rlung.* On each occasion that she came to the clinic she told Dr. Dhonden about voices that spoke to her. As these voices had been with her for 17 years she had become quite attached to them, even though what they said to her often caused her great distress. As what she said to Dr. Dhonden during each of the consultations was very lengthy, in what follows I have summarised it.

On her first visit that I witnessed she said that she had been experiencing 'echoing sounds' and many visual hallucinations. She had had joint pains, a vibrating sensation in her left elbow, pains in her chest, and blurred vision. She said that a number of involuntary gestures had occurred to her face: one was frequent grimacing, and another was closing her eyes quickly and tightly. The voices had been attacking her and she felt depressed and confused. Her pulse was 'thin', 'slow' and 'empty'. Dr. Dhonden gave her three medicines for one month: *ba lu lnga pa,* to be taken in the morning; *pri yang lnga pa,* to be taken at lunch time; and *se 'bru lnga pa* to be taken with her evening meal.

The next time she came to the clinic, one month after, she had suffered from joint pains, convulsions, panic attacks, loss of control of her bowel, and vomiting. She had seen a white mist in her bedroom on a number of occasions and complained about an 'energy' swirling around her head attacking her. She said that the voices had claimed to be angels. She added that whenever she said that she was feeling better the voices would threaten to leave and this upset her because she did not want the voices to leave. Her pulse was 'prominent', 'empty' and 'slow'. Dr. Dhonden gave her three medicines for one month, this time two different medicines: *se 'bru lnga pa,* to be taken in the morning;

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medicine if they were already taking a large amount of other medication. Tibetan medicine was not prescribed when there was an uncertainty about any adverse reaction with a biomedical drug, for example patients taking Warfarin to prevent thrombosis.

bre ga lnga pa, to be taken at lunch time; and *se 'bru dangs gnas* to be taken with her evening meal.

On her next four visits her symptoms where similar to what is listed above, aches and pains, depression, panic attacks, and visual and auditory hallucinations. At one point the voices had told her to light a candle in a catholic church and they would pay for it. On her way out of the church she found 20p on the floor. On another occasion she had been shouting at the voices out in the street. A concerned passer-by, noticing her distress, had asked her if she wanted an ambulance; she said no, this has been happening for the last 17 years. At one point she mentioned that several diagnoses had been made of her condition by Western psychiatrists. At different times the labels 'schizophrenia', 'bipolar', 'epilepsy' and 'manic depression' had all been used to describe her condition, and she found all this very confusing.[12] Doctor Dhonden's pulse reading showed slight fluctuations in her condition and he adjusted her medication accordingly.

A number of conclusions can be made from these ten patients concerning the Tibetan medical approach to mental disorders in the Western setting of the Tara clinics. First, generally speaking, mental disorders are related to disturbances in the wind humour—in most cases the 'life supporting wind' (*srog rlung*). Second, the form of the disorder and the treatment vary both according to a patient's specific individual constitution and illness and throughout the course of the sickness. Third, pulse diagnosis is an essential diagnostic technique used to verify the changing nature of the disorder. And finally, mental illness known as *srog rlung* can take various forms from mild depression and anxiety to extreme mental disturbance.

THE APPROACH TO MENTAL ILLNESS (*SEMS NAD*) IN THE CLINIC IN DHORPATAN

The Tibetan medical clinic in Dhorpatan, west Nepal, was the main source of health care provision in the valley. At the other side of the valley there was a biomedical sub-clinic that was run by one of the local Tibetan girls who had received a basic health care training in

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[12] Estroff 1993 has indicated that healthy individuals have multiple social roles, and the use of labels such as 'schizophrenic' can lead to the erosion of such roles, prolonging the chronic nature of the illness.

Dharamsala, but most people—whether Tibetans or Nepalese—used the Tibetan medical clinic. On average, about three people attended the clinic each day, quite often more people would come, the most I witnessed in one day was 15. When a patient arrived, first Amchi Gege would listen to what the patient had to say about his or her condition, then he would ask questions to refine his understanding, after this he would take the patient's pulse. If the patient had brought a urine sample this would be examined at the beginning of the consultation.

During the last ten months of my stay in Dhorpatan I recorded details of clinical interactions involving 153 patients. For these patients Amchi Gege diagnosed and classified 42 different types of disease. The majority of these were single phenomena, i.e. occurred only once or twice in that time, such as oedema (*kya bab*), a type a fever caused by a physical blow (*dram tshe*), a disorder of the serum (*chu ser*), and so on. A few disorders were suffered commonly by numerous patients, for example there were 29 patients who were diagnosed as suffering from types of tumour (*skren*), and 13 patients who were diagnosed with a type of chronic digestive disorder (*bad kan smug po*).[13]

When patients relayed their symptoms to Amchi Gege, they invariably related their condition to physical ailments, such as poor appetite, fever, menstruation problems, various aches and pains, skin disorders, lumps and swellings, diarrhoea, difficulty in breathing, and so on. It was striking that, in contrast with what we have just seen for the patients in the Tara clinics, patients who came to the clinic in Dhorpatan, whilst I was there, rarely complained about the state of their psychological well-being. Of the 153 patients that I recorded 52 were Tibetan and the rest Nepalese, and none of these patients used words, neither in Tibetan nor in Nepali, that related directly to their psychological condition.

Whenever mental illness was diagnosed in Dhorpatan during the time that I was there it was always related to the action of 'harmful spirits' (*gnod pa*). This type of sickness is known accordingly as *gnod pa* ('to cause harm'), and it was a common illness amongst both the Nepalese and the Tibetans living in the valley. There is a large overlap between Tibetan religious conceptions and Tibetan medicine. Amongst the range of factors that can bring about disease according to Tibetan Medicine are: adverse environmental conditions, astrological influ-

[13] For a full list of disease classification for the 153 patients, see Millard 2002.

ence, and harmful spirits. When the cause of a disease is known to be harmful spirits, or negative influences from the environment, such as specific kinds of 'pollution' (*grib/sgrib*),[14] or harmful spirits, then medicines alone will not suffice to bring about a cure, and the negative influence must be addressed directly through ritual. In Dhorpatan the person who was in charge of all this activity was the young head lama of the community, Geshe Tenzin Dhargye. Therefore, in the arena of health care in Dhorpatan there was a division of labour between Amchi Gege who treated all the patients whose condition could be treated by conventional Tibetan medical internal or external therapies, and Geshe Tenzin Dhargye who treated the few patients whose condition required ritual intervention. Sometimes patients who suspected their illness was caused by spirits went directly to Geshe Tenzin Dhargye.

The reason why spirits cause sickness was often given by people in Dhorpatan as an act of retribution resulting from human activity which had caused pollution or damage to the natural environment, such as polluting rivers, streams or lakes, or cutting down trees or quarrying work. Numerous classifications of such spirits and divinities can be found in Tibetan religious texts.[15] Various types of spirits are also listed in the main medical text. Chapter one of the fourth *tantra* of the *Rgyud bzhi* on pulse diagnosis has a section which discusses the characteristics that indicate spirit caused sickness: the beat is irregular, the pulse stops at sporadic intervals, it is 'taut' (*'then pa*) like a rope, the pulse feels like 'two beats occurring simultaneously' (*lcam dral*, literally 'brothers and sisters', or 'consort', 'retinue'). These qualities may be present on their own or in combination. The following chapter on urine analysis also has a section on the characteristic features of urine which indicate spirit caused sickness.[16] Both chapters relate these diagnostic features to specific spirits, such as the *dkor bdag, rgyal po, klu btsan, byang sman, dmu, klu, sa bdag, gnyan*, and so on. If in Dhorpatan, the pulse or urine appeared to denote *gnod pa* illness (i.e. illness caused by 'harmful spirits'), then divination would always be performed to confirm the diagnosis.

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[14] A form of pollution associated with certain kinds of activities. When it accumulates sufficiently it can cause illness. For further information on *(s)grib* see Millard 2002, Daniels 1994, Lichter and Epstein 1983, and Schlicklgruber 1992.

[15] For further information on these classifications see Samuel 1993, Beyer 1973 and Nebesky-Wojkowitz 1956.

[16] For a description of the procedures involved see Donden 1986 and Millard 2002.

In the context of Dhorpatan I will focus here on the class of malevolent spirits known as *'dre or gdon.* Both these terms relate to a class of malevolent spirits that cause harm or create obstacles for people. Spirits are not just something spoken about in religious texts. For the people in Dhorpatan they are an everyday reality. Hardly a week went by in which I did not hear of their presence in the valley in one form or another. Most of the Tibetans and Nepalese who live in the valley have a firm conviction in the reality of illness caused by spirits as part of their traditional world view (which is of course a major difference between them and Western patients). For them, the environment in which they live is replete with such entities, and the health of the community and the individual depends on maintaining a harmonious relationship with these beings. Many people in Dhorpatan claim to have seen spirits or witnessed their presence. Most often what they saw was luminous spheres hovering above the ground or moving through the air; these were referred to as 'spirit fires' (*'dre me*).

Geshe Tenzin Dhargye explained to me that some *'dre* are spirits of the dead who because of some unfulfilled task, such as an existing vendetta, remain attached to the place where they lived. He said that when this happens, it is the 'consciousness' (*rnam shes*) of the deceased person that continues to linger at the former household, homes of relatives and neighbours. Such a spirit is known as a *shi 'dre.* He told me that two years before, he and another Bon po lama were called to a village near Jomson to try and help a sick woman. They recognised the sickness as spirit possession, and in response they tied blessed cords around both of her third (or ring) fingers. The reason for this is that these fingers are believed to be points through which spirits can enter, take possession of and exit the human body; by blocking them with blessing cords they effectively trapped the spirit inside the sick woman's body. They then proceeded to question the spirit about its motives. It turned out that the spirit causing the harm was a person from a nearby house who had died three years before in a hospital in Kathmandu. They found out the cause of the problem: the dead person's relatives had not performed the correct ritual after the death of that family member. The two lamas then taught the dead person's errant consciousness (*rnam shes*) the relevant prayers and mantras. After this they removed the blessed cords and the sick woman returned to consciousness, having no recollection of what had happened.

On this subject, the senior medical student in the medical school, who came from the village of Jharkot in Mustang, remarked to me that in his home area it was very common for the consciousness of a person, whether deceased or not, to enter into the body of another, and was curious to know whether this was the same in my country. Another type of *'dre* that I was told about by Geshe Tenzin Dhargye is the *gson 'dre*. This is a person, usually a woman, who has an inherent power to cause harm; this power is passed on through the family line.[17]

The following is an example of mental illness resulting from *gnod pa*, and how it was dealt with typically, in Dhorpatan. One afternoon I was sitting near the medical school when a Nepalese girl ran past me in great distress. She was shouting something to the Nepalese men who were working on the new medical school building. One of the men put down his tools and left with the girl, he was a *jhānkri*, a local healer. Shortly afterwards, Geshe Tenzin Dhargye told me that the girl's sister had been suddenly beset by a strange illness.

The following day Geshe Tenzin Dhargye was searching for me because he had been called to the house of the sick Nepali woman to do a *mdos*[18] ritual to placate the spirit causing the girl's illness. He said that she was sitting in the house, not conscious of anything that was happening around her, and shaking all the time. The day before, the *jhānkri* had done a ritual, during which two chickens had been sacrificed. The *jhānkri's* ritual had not improved the condition of the girl and her family had then asked Geshe Tenzin Dargye for help.

On the following day, two of Amchi Gege's monk medical students told me that they had been to see the sick Nepalese woman. They gave the same description of her condition as Geshe Tenzin Dhargye, but added that her eyes were turned back so that the cornea could not be seen. They were totally convinced that she was suffering from *gnod pa*. On the next day I accompanied Geshe Tenzin Dhargye to visit her. She was still sitting in the corner of the house, seemingly oblivious to what was happening in the room, with her head nodding up and down to a steady rhythm. She appeared to be in her early twenties. Geshe Tenzin Dhargye lit some incense and began reciting a prayer. Whilst doing this

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[17] A short account of both these classes of *'dre* can be found in Tucci (1980: 187).

[18] This *mdos* ritual involves offering an effigy of an afflicted person to the spirit in order to appease it. Other ritual objects are also offered such as a 'thread cross' (*nam mkha'*). For detailed information on the *mdos* rites see Karmay 1998, Norbu 1995 and Snellgrove 1967.

he occasionally threw barley grains around the room and wafted the incense into the woman's face. I asked her family if she had ever suffered from something like this before. They said this was the first time. It had all begun five days before when she had been up in the hills with their buffaloes. She had been in a place where there is a small lake. Geshe Tenzin Dhargye thought it was possible she had washed in the lake and thereby offended the *klu* spirits who reside there. He had asked one of her relatives to go up to the lake and burn some juniper and set up a prayer flag and apologise to the *klu*. This had not yet been done, but they said it would be done quickly.

The next day another *jhānkri* was brought from a nearby village. He was reputed to have more power than the first *jhānkri*. I did not see his ritual performance, but within a few days the woman was well again. Around this time I met her father at the medical school. He was very happy about his daughter's recovery and had brought a bag of meat as a gift for the 'doctor lama'. I asked him which treatment or ritual did he think had brought about the cure. He replied that he did not attribute it to any one particular cause, but to the combination of everything together.

Gnod pa does not always take the form of mental illness. In Dhorpatan most cases of *gnod pa* that I recorded where primarily understood as physical disorders caused by angered spirits. Yungdrung, one of the Tibetan medical students who had been brought up in Dhorpatan, recounted to me an event that had happened to him when he was ten years old. He said that he had been playing in a location where a spring emerges from the bottom of a large rock. The Tibetans acknowledge this site as a dwelling place of the *klu* class of spirits, and as such it is surrounded by Tibetan prayer flags. Yungdrung and his friends found a frog in the stream, and as it appeared very colourful, they took it from the stream and played with it, eventually killing it. The next day Yungdrung could hardly move his legs and it took the ritual intervention of a Tibetan lama to enable him to return to health. Whilst I was in Dhorpatan, the same kind of disorder befell a local Nepalese boy who had inadvertently used the abode of a *klu* spirit as a toilet. This time a local *jhānkri* was called to resolve the problem.

On another occasion, one of Amchi Gege's students was walking home at the end of the day. At a certain point on the path what he took to be a spirit shot past him in the form of a ball of white light. He said that it had a tail like a shooting star. It stopped at the other side of the

river and after hovering a while it disappeared. Shortly afterwards, he started to feel ill, and by the next day he had a strong fever. Within a few days a large 'boil' (*gnyan 'bur*) appeared on his neck. Traditionally boils are thought to be caused by the *gnyan* class of spirits, although this is not the only cause. He received medicines from Amchi Gege, and appropriate rituals were performed at his house. He was away from the medical school for about two weeks as a result of the illness.

On two occasions during my stay in Dhorpatan patients were diagnosed as suffering from a condition where their 'soul' (*bla*)[19] had been abducted by a spirit. This can result in mental illness, but this was not the case with either of these patients, one of them was suffering from a sore throat and fever and the other from pains moving around to different locations in his body. In both instances the appropriate ritual was performed.[20] In the foregoing we have seen that in Dhorpatan mental illness may result from *gnod pa*, but we also saw that *gnod pa* can also take the form of a physical illness. Amchi Gege is fully aware that mental illness is not confined to *gnod pa* since there is a range of causes that can disrupt the humours which are responsible for an individual's state of mental well-being.

On one occasion after I had just returned to the valley having spent some time in Kathmandu renewing my visa, I heard the gruesome story of a young Nepali woman having killed her child. This had happened whilst she had been up in the mountains collecting firewood. The Tibetan person telling me the story was convinced it was due to spirit possession. When I discussed this with Geshe Tenzin Dhargye, he did not think this was the case, rather he thought it was a case of 'mind crack' as he put it, using the English phrase.

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[19] There is some confusion as to exactly what the Tibetan word *bla* conveys; sometimes it appears as a 'vital force' (*tshe yi rtsa*) and is thus similar in meaning to the Tibetan word *srog*, and at other times it appears as a 'soul'. For instance in the second volume of the *Rgyu bzhi*, in one location in the discussion of 'life channels' the *bla* appears as a life force which circulates around the body according to the lunar cycle, and in another location it appears as a 'soul' which can leave the body (for a fuller discussion of this see Millard 2002, and Gerke, this volume).

[20] I have described the ritual as it occurred in Dhorpatan in Millard 2002. For descriptions of the ritual in other locations see Lessing 1951, Bawden 1962, Mumford 1989, Karmay 1998 and Norbu 1995.

Mental Disorders in Tibetan Medicine

The Anatomy of the Subtle Body and the Classification of the Channels in Tibetan Medicine

Tibetan medical teachings clearly overlap with Tibetan Buddhist notions about the nature of the mind and the body and the relationship between the microcosm of the human constitution and the macrocosmic environment. This relationship is documented in detail in the Buddhist and Bon *sūtra* and *tantra*. Tibetan medical notions of anatomy are very much influenced by tantric cosmology, particularly those found in the highest yoga *tantras* (*annuttarayoga*). These texts deal with two levels of practice: the first is the generation stage where the practitioner visualises oneself as the tantric deity; and the second stage involves the manipulation of the 'subtle winds' in the body. It is the second stage that connects directly with Tibetan medicine. In this section of the tantric texts we hear of a vital force or 'wind' (Tib. *rlung*, Skt. *prāṇa*) that underlies all physiological and psychological processes. As Wangyal puts it, "(i)t is the fundamental energy from which all things arise, the energy of the *kunzhi*, the basis of existence" (2002: 77). This 'wind' runs through the subtle body which consists of a vast network of channels (Tib. *rtsa*, Skt. *nāḍī*)[21]—traditionally 72,000 are spoken of (Gyatso 1982: 23), but in other places we hear of 84,000, or sometimes 360,000 (Wangyal 2002: 81). As we will shortly see, some of these 'winds' are related to physiological functions and are mentioned in the main Tibetan medical text, the *Rgyud bzhi*. There are three main channels, which run down the centre of the body. At various points on the central channel there are seven 'energetic centres' (Tib. *'khor lo*, Skt. *cakra*), which are major confluence points for the various channels.

Of particular relevance here is the notion that the mind is intimately related to the 'wind' or 'vital energy' that flows through these channels and thus through the whole body. It is said that the 'mind' (*sems*) rides on the currents of 'wind'; wherever the mind goes, 'wind' follows it (Samuel 1989). In the Bon mother *tantra* this metaphor is expanded to include four elements: 'the horse' represents wind; 'the path' is the channels; 'the rider' represents the mind; and 'the armor' is the seed syllables from which the tantric deity manifests and into which it dis-

[21] The Tibetan word *rtsa*, denotes 'channel', 'vein', 'artery', 'nerve', and 'pulse'.

solves (Wangyal 2002:81). In the tantric texts, detailed accounts are given of the relationship between 'wind' and mind during normal life, dreams, death, meditation, and on achieving liberation from *samsāra* (Rinbochay and Hopkins 1985, Gyatso 1982). Certain yoga practices (*rtsa rlung*) involve the manipulation of these 'winds' with the aim of gaining spiritual insight into the nature of mind (Samuel 1993: 236).

Whereas in tantric practice, 'winds' and channels are used for meditational and purificatory practice, in Tibetan medicine 'winds' are immediately related to all-over bodily processes as well as mental health and illness (cf. Chaoul, this volume). Body and mind are seamlessly interwoven, forming inseparable parts of a psycho-physical continuum. Chapter four of the second volume of the *Rgyud bzhi* deals with the subject of anatomy which is where we find a detailed discussion of the relationship of 'wind' to the mind.[22]

The first class of channels consists of the three 'channels of formation' (*chag pa'i rtsa*). These are the first channels to be formed in the human embryo. The root cause that leads beings to be born into samsaric existence is a deep 'fundamental ignorance' (Tib. *ma rig pa*, Skt. *avidyā*) of their own nature, this leads to a false 'sense of self' (*bdag 'dzin*), which leads to the three afflictive emotions of 'desire' (*'dod chags*), 'aggression' (*zhe sdang*) and 'ignorance' (*gti mug*). These in turn generate the three humours of 'wind' (*rlung*), 'bile' (*mkhris pa*) and 'phlegm' (*bad kan*). The second series of channels are called the 'channels of existence' (*srid pa'i rtsa*). These channels are intimately related to our psychological state, our abiltity to perceive and give meaning to perception, and our emotional and cognitive capacities.

The heart centre, and particularly the 'life channel' (*srog rtsa*) situated at the heart centre, is the location of the most important of the five winds in connection with Tibetan psychiatry, the 'life holding wind' (*srog 'dzin rlung*). This 'wind' has a gross, subtle and a very subtle aspect (Gyatso 1982). The second life channel is the location of the very subtle wind that supports the very subtle mind which together transmigrate from life to life. Around the heart centre are four further channels radiating out in each of the cardinal directions. The channel in front (east) relates to the consciousness of the five senses. Each of the senses is rendered functional by a subsidiary wind that branches off here from the 'life supporting wind'. The channel behind (west) relates

[22] For a detailed discussion of these channels and winds see Meyer 1988 and Millard 2002.

to the consciousness of conflicting emotions. The channel to the left (south) relates to the mental consciousness, in other the words the consciousness related to intellectual processes. The channel to the right (north) relates to the store consciousness, the consciousness which is the ground of all experience.

What we perceive, and how we relate to the objects of perception depends on flows of information between the first channel of existence located in the brain and the second channel of existence located in the heart centre. Sensory information is transmitted by the 'pervading wind' through the nervous system to the brain where it is passed on to the heart centre. In the heart centre it is transformed into an object of perception. Thus the sensory data that is gathered in the brain is rendered intelligible by the heart centre. In discussions I had with Amchi Gege from Dhorpatan on this subject, he was firmly of the opinion that the seat of the mind is the heart and not the brain. This was also the opinion of Dr. Dhonden from the Tara Clinics in the UK.

The Channels Related to the 'Life Force' (*Bla*)

The final series of channels that are mentioned in the *Rgyud bzhi* are the three 'life channels' (*tshe yi rtsa*). Although they are described as channels, what is actually referred to in the text is the movement of the 'life force' (*bla*) in the body. The first, which is described as the 'one that penetrates the whole of the head and body',[23] is a life force, which circulates round the body according to the lunar cycle. On the first day of the cycle it is located at the feet, it gradually moves up the left side of the female body, and the right side of the male until the full moon on the fifteenth day of the Tibetan month when it reaches the head. It is important to know the 'life force location' (*bla gnas*) before doing moxibustion or bloodletting. The second life channel is called the one 'that accompanies the breath'; this relates to the wind that is drawn in through the breath.

The third life channel requires some explanation as it relates directly to certain forms of illness and the use of ritual in healing, which I discussed earlier. The *Rgyud bzhi* says, this channel 'is like the soul (*bla*) and roams about'. Both Buddhist and Bon philosopy have the

[23] I have used Meyer's translations of the titles of the three life channels (1988: 125).

same view of the nature of the self. The individual consists of the five 'aggregates' (Tib. *phung po*, Skt. *skandha*) of form, feelings, perceptions, mental formations, and consciousness. The aggregates give the appearance of an abiding self, but in reality such a self does not exist. What transmigrates from life to life is a stream of consciousness propelled by the force of afflictive emotions and the karma they generate.

However, in the medical school in Dhorpatan the three human components that were most often spoken about were the 'body' (*lus*), the 'consciousness' (*rnam shes*) and the 'soul' or 'life force' (*bla*). The *bla* acts as a kind of vital principle essential to the healthy functioning of the body. It can leave the body of its own volition, usually through the channel at the ring finger, or it can be absconded by harmful spirits. Its absence is potentially fatal. The condition of the *bla* can be diagnosed by palpating the ulna artery on the forearm below the elbow.

Earlier I referred to two patients in Dhorpatan who during my stay were diagnosed as suffering from an absent *bla*. As I mentioned above, the *bla* was spoken about in different ways: sometimes it appeared to be a soul that could survive death; sometimes it was talked about as a vital energy that circulated in the body. Amchi Gege, when he was teaching me about the *bla* pulse, explained that it originates from the consciousness; he said the *rnam shes* is like the mother and the *bla* is like the son. He added that it is the 'support' (*rten*) of the body. He said that after death the *bla* should 'go with the *rnam shes*'. It may remain behind in the place where the person died but this is not propitious. One of the medical students in Dhorpatan, following what he had been taught by Amchi Gege, described it in physiological terms as the most refined nutrient of the metabolic process.[24] When I asked Geshe Tenzin Dhargye for clarification he said that the *bla* should be thought of along with another two aspects of the mind: the *sems* and the *yid*. He explained that *sems* signifies the mind that consists of constantly shifting thoughts; *yid* is a deeper layer of mind in which the thoughts circulate. He gave the metaphor of *yid* as a village and *sems* as people wandering about in it. He said that the *bla* provides the energy for all this to happen. He added that when a person dies, the *bla*, *yid*, and *sems* are separated and this causes great mental turmoil for the deceased person.

[24] The phrase he used was 'the nutrient of the nutrient' (*dangs ma'i dangs ma*). Usually the most refined nutrient produced from the metabolic process is the 'vitality fluid' (*mdang*).

In the Bon ritual that is carried out for the dead, the *bla*, *yid*, and *sems* are first brought back together, to give the deceased person peace and mental clarity.[25]

When I discussed all this with Lopon Tenzin Namdak at the Bon monastery of Triten Norbutse in Kathmandu, he said that the notion of the *bla, yid* and *sems* is important in the Bon religion. He explained that *sems* is the 'mind'; he likened it to 'a lame man who can see'. *Yid*, he said, is a 'subtle wind', which supports the mind; the metaphor he used for this was 'a blind horse'. He explained that *bla* is the 'karmic trace' (*bag chags*), which sets everything in motion; he said *bla* is like the food for the lame man and the horse. This is how the *bla* is conceptualised in Bon philosophy, but from a ritual point of view it is treated like a soul or a vital life force.[26] Lopon Tenzin Namdak also pointed to this aspect of *bla* when he explained that traditionally in Tibet, objects in the natural environment could be used as its support, such as a 'soul tree' (*bla shing*), a 'soul lake' (*bla mtsho*), a 'soul turquoise' (*bla g.yu*) or a 'soul mountain' (*bla ri*). He said that the early kings of Tibet had Mt. Kailash as the support of their *bla*. It was thought that if the snow melted it showed the weakening of their vital energy; he added that now there is much less snow on the mountain.

THE THREE HUMOURS AND TIBETAN PSYCHIATRY

In Tibetan medical theory there are five forms of each of the humours. Each of these 15 subdivisions is responsible for certain psychological and physiological functions and is also associated with a specific location in the body. Tables 2, 3 and 4 summarise these functions and locations. They show that the three humours are the guiding force underlying all psychological and physiological processes.

Although the bile and phlegm humours have aspects that are related to psychological functions, it is the wind humour that is of most relevance here. In connection with our mental state of being it is the 'life holding wind' which is of most importance, since it provides clarity to the mind and is intimately related to mental disorders. From Table 2 we

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[25] A short description of the ritual is given in Norbu 1995: 87; a full account of it can be found in Kværne 1985.

[26] For more information on the *bla* as the soul, see Tucci 1980: 190 and Stein 1972: 226.

can see that it is associated with the top of the head, but as mentioned earlier it is also located in the 'life channel' situated at the heart centre. In this location it serves as the support for the consciousness in the body and the very subtle mind which passes from life to life. We also saw that the heart centre is the location of winds and channels that are responsible for what we perceive, and our cognitive and emotional functions. From Table 2 we can also see that the 'upward moving wind' and the 'pervading wind' are related to mental processes.

Before moving on to focus on the pathology of mental illness in Tibetan medicine, it will be first useful to consider at a general level the qualities of the humours which lead to health or sickness. The three humours have a dual nature: if they are in their right proportions and locations, they are the cause of health; if by some means they are disturbed, this will result in illness. The *Rgyud bzhi* divides the cause of disease into two categories: the 'root cause' (*rgyu*) of disease is the fundamental ignorance which leads to the three mental poisons and the three humours in the psychophysical continuum of the human constitution. The text goes on to give four main 'contributory causes' (*rkyen*) of disease: season, diet, behaviour, and harmful spirits. In chapter nine of the second volume of the *Rgyud bzhi* these appear amongst a list of general causes of disease: season, harmful spirits, incorrect treatment, poison, diet, and negative karma.

Table 2: The five types of winds

THE FIVE WINDS	LOCATION	FUNCTION
life holding wind (*srog 'dzin rlung*)	top of the Head	swallowing, breathing. shedding tears, sneezing. belching, clarity of mind
upward moving wind (*gyen rgyu rlung*)	chest	Speech, body strength, body colour, gives strength to the mind, clear memory
pervading wind (*khyab byed rlung*)	heart	capacity for movement. aids thinking
fire companion wind (*me mnyam rlung*)	stomach	separates the nutrients from the wastes during digestion and helps form the body's constituents
downward expeller wind (*thur sel rlung*)	genital/rectum	flow of sperm, menstrual blood, urine and stool

Table 3: The five types of biles

THE FIVE BILES	LOCATION	FUNCTION
digestive bile (*mkhris pa 'ju byed*)	between digested and undigested food	digests food. provides body heat and strength, supports bile humour
colouring bile (*mkhris pa sgrub byed*)	liver	provides the colour of bodily constituents
accomplishing bile (*mkhris pa mdang sgyur*)	heart	body heat, courage, pride, intelligence, will power
eyesight bile (*mkhris pa mthong byed*)	eyes	provides eyesights
complexion clearing bile (*mkhris pa mdog gsal*)	skin	gives a clear complexion

Table 4: The five types of Phlegm

THE FIVE PHLEGMS	LOCATION	FUNCTION
Supporting phlegm (*bad kan rten byed*)	chest	Provides body moisture and supports the other phlegms
decomposing phlegm (*bad kan myad byed*)	stomach	Breaks down the food in the stomach
experiencing phlegm (*bad kan myong byed*)	tongue	provides capacity for tastes
satisfying phlegm (*bad kan tshim byed*)	head	provides the sensation of satisfaction from the sense
connecting phlegm (*bad kan 'byor byed*)	articulations	connects the body's joints and enables movement of the limbs

The treatment of mental illness is covered in various locations in the *Rgyud bzhi*. The third volume of the medical text is concerned with Tibetan nosology. As the wind humour is of particular relevance to mental functions, chapter two of the third volume dealing with wind disorders is of general relevance. Of particular relevance is what can be called the psychiatric section; this is section 11 of the third volume which comprises chapters 77–81. Medical material related to Tibetan psychiatry can be found scattered in other locations of the third volume, but these are the most relevant chapters.

Chapter two of the third volume discusses 63 kinds of wind disorders. Each of the humours can be disturbed by the contributory factors listed above or by the presence of a factor with similar qualities to the humour. In addition to this, the text lists causative factors that are specific to each humour. Specific causative factors of wind disorders are: eating too much bitter, light and coarse foods; extreme exertion, grief, intense mental activity, and so on.[27] The symptoms which indicate a disturbance of the wind humour are: the pulse is 'empty' (*stong*) and 'floating' (*rkyal*); the urine looks like water and as it cools down it becomes thinner; the tongue is dry, red and rough; insomnia; yawning; dizziness; shifting pains, and so on.[28] As we saw earlier, most of the patients who came to the Tara clinics with mental disorders had an 'empty' pulse.

Disturbances in the wind humour can lead to a range of pathological conditions affecting physiological and psychological functions. It can also lead to pathological conditions of the nervous system, causing a range of symptoms such as: aches and pains; difficult mobility; muscular spasms; numbness and sensory dysfunction. As 'wind' is responsible for the circulation of the blood, disturbances here may lead to high or low blood pressure (*khrag rlung*). If the 'life bearing wind' is disturbed in its location in the heart centre, this will lead to mental illness. If the disturbance is mild then the individual may feel slight mental discomfort, anxiety, or mild depression. For Tibetans all these kind of mental disorders are referred to as *srog rlung*, which is the Tibetan name for the 'life bearing wind'. If the location of the 'life bearing wind' in the channel at the heart centre is invaded by one or both of the other two humours, then more severe forms of mental illness will arise. In this way the classification of mental illness in Western psychiatry into neurosis and psychosis can be understood in Tibetan medical terms by the degree and intensity of disturbance of the 'life bearing wind'. We have seen in the earlier discussion of patients coming to the Tara clinics, that Dr. Dhonden diagnosed srog rlung for patients with quite different forms of mental disorder.

What chapters 77 to 81 of the third volume of the *Rgyud bzhi* have in common is that they are all concerned with illness caused by 'harm-

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[27] For a full list of specific causative factors of leading to imbalances in the wind humour see Clark 1995: 79 and Epstein and Rabgay 1982: 24.

[28] For a full list of symptoms indicating a wind condition see Clark 1995: 85 and Epstein and Rabgay 1982: 75.

ful spirits' (*gdon*): chapter 77 deals with negative influences arising from the 'spirits of the elements' (*'byung po'i gdon*); chapter 78 deals with 'spirits that cause madness' (*smyo byed kyi gdon*); chapter 79 deals with 'spirits that disrupt memory' (*brjed byed kyi gdon*); and chapters 80 and 81 deal with 'planetary spirits that cause strokes and epilepsy' (*gza'i gdon*) and 'leprosy', caused by '*klu* spirits' (*klu'i gdon*).[29]

In Tibetan medicine there are numerous spirits that can cause both physiological and mental sickness.[30] In Dhorpatan, spirits could cause sickness in one of three different ways: the spirit could cause disruption in the three humours from outside; the spirit could cause harm by possessing the individual; and the spirit could capture the person's *bla*. We have seen that one of the main causes of mental illnesses is when the 'life supporting wind' is displaced from its location in the life channel at the heart region by the invasion of this channel by either or both of the other two humours. *Gnod pa* disorders indicate that either the spirit is the cause of the other two humours invading the location of the 'life supporting wind', or the spirit enters the body through certain entry points.[31]

In a like manner to Western psychiatry, diagnosis of mental disorders in Tibetan medicine involves assessing the signs and symptoms of the patients to find the underlying pathological condition. There may be some overlap between symptoms in the two traditions, such as feelings of depression or anxiety, but there is clearly a culturally conditioned, fundamental divergence in Western and Tibetan of the signs, general epistemology, etiology, nosology, and taxonomy of the individual condition, including diagnostic and treatment methods, as will be shown in the following section. In both Dhorpatan and in the Tara clinics, examining the pulse was the most important form of diagnosis. Tibetan medical treatment for mental illness is a combination of dietary and behaviour modification, and appropriate medication. External treatments can also be used such as moxibustion, massage or acupuncture.

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[29] See Clifford 1984 for a translation of chapters 77, 78 and 79.

[30] Spirit possession is not always harmful. In Tibetan society spirit possession is consulted by certain individuals for the purpose of divination, healing, or for providing advice in the community. Such people are known as *lha pa, lha mo* or *dpa' bo* (Day 1989, Nebesky-Wojkowitz 1956: 398-443, Prince Peter 1978, Berglie 1976). The possessing agent may be a god, goddess, or a being from one of the many spirit classes. The person possessed can be a monk or a layperson.

[31] In Dhorpatan the entrance point was always the channel at the third finger of each hand. This corresponds also to the entrance point noted by Berglie 1976.

APPROACHES TO THE CLASSIFICATION OF MENTAL ILLNESS IN WESTERN PSYCHIATRY

The approach taken to mental illness in Western psychiatry, as with disease generally in biomedicine, can be divided into four areas: etiology, pathology, epidemiology, and therapy (Scheff 1967). Within psychiatry there are different views on the pathological mechanisms underlying mental illness. In the following discussion I will begin by considering the perspective in psychiatry that all mental disorders can be reduced to a physical pathology. The section will then move on to consider: systems of classification of mental disorders in Western psychiatry; critical perspectives on the Western psychiatric approach; and the perspective in psychiatry that conceptualises mental illness through psychopathological terms. We will see that two major problems for Western psychiatry are: how to account for mental disorders with no discernable physiological basis; and the nature of the relationship between the mind and the body.

A major perspective in Western psychiatry is that illnesses of the mind are the same as illnesses of the body in that they are both grounded in a physical pathology. Helman (2000) refers to this view as the 'biological approach' to mental illness. Upholders of this view consider the biomedical model of disease used in general medicine as equally applicable to psychiatry. The biomedical model holds that diseases are pathological entities deriving from somatic lesions or dysfunctions in biological systems. Following in the tradition of Pasteur and Koch these somatic lesions and dysfunctions may be related to infection, or in the tradition of Virchow to cellular pathology. An example of a psychiatric illness which can be related to a physical pathology in this way is neurosyphilis, or to use its old name, general paralysis of the insane, caused by infection of the brain with the bacteria Treponema pallidum.

Another essential element of the biomedical model is the notion of disease entities. A disease entity involves: a recognised group of symptoms, a standard clinical course, and related post-mortem information. The disease entity produces physical signs that can be clinically assessed, and symptoms which are the expressions of suffering individuals. For example if a person is suffering from a type of depression that involves signs of waking early in the morning, loss of weight and altered cortisol metabolism, and corresponding symptoms of sadness, lack of energy and interest, poor concentration and suicidal tendencies

(Roth and Kroll 1986: 57); these signs and symptoms are indicators of a somatic pathological condition that can be treated by tricyclic antidepressant medication. It is acknowledged that symptoms may be expressed in specific cultural idioms[32] but the disease itself is taken to be an event existing outside of its social or cultural context; it is a pathological entity in the nature-based framework of human biology.

An exponent of the biological approach is Kiev (1964). In his view the cultural expressions of mental disorders may vary in different cultural contexts, but the basic underlying physiological features are universal and constant. For Kiev, the form of mental illness which Western psychiatry calls 'schizophrenia', has its basis in human biology, and will be found in all cultures, though the specific content of the delusions will vary according to the cultural context. In this way he goes on to classify several well documented 'culture bound' disorders according to Western psychiatric categories. The Latin American disorder *susto* (soul loss) he identifies with 'anxiety', spirit possession found in many societies with 'dissociative states', 'evil eye' as a phobic state, and the disorder *Shinkeishitsu* (an obsessional condition amongst young Japanese) as 'obsessional-compulsive neurosis'. Kiev's perspective on schizophrenia is supported by evidence provided by The International Pilot Study of Schizophrenia sponsored by the World Health Organisation. The study gathered data on 1202 psychotics in nine countries. This data showed the main characteristics of schizophrenia to be present in each country, which can be taken as evidence that it is a universal disease category (WHO 1975).[33]

In biomedicine diseases are classified according to etiology and structural pathology, for instance viral pneumonia or broncho-pneumonia. If the etiology and pathology remain uncertain then the symptoms are grouped together into syndromes, until the etiology becomes clear. For example the transition from the syndrome AIDS (Acquired Immune Deficiency Syndrome) to the causative factor HIV (Human

[32] There is now a long-standing tradition in medical anthropology which stresses the role of culture in patterning not only how symptoms are expressed (Kleinman 1980, Obeyesekere 1985, Nichter 1981), but in defining what disease is. As Good (1994:53) explains it, "(c)omplex human phenomena are framed as 'disease' and by this means become the object of medical practice. Disease as its ontological grounding in the order of meaning and human understanding".

[33] A follow-up study published a few years later provided evidence of cultural influence on the origin, symptoms and course of schizophrenia (WHO 1979).

Immunodeficiency Virus), or more recently the transition from SARS (Severe Acute Respiratory Syndrome) to the causative factor of the Coronavirus. With some psychiatric disorders, such as neurosyphilis, Down's Syndrome and Alzheimer's disease, there is a clear etiology and physical pathology. However, although there has been a long standing quest to isolate the biomedical mechanisms underlying mental illness (Fabrega 1987), it remains the case that for most mental disorders no related physical pathology has yet been found and as such they are mostly classified according to symptoms.

Up until recently two major official classifications of mental illness in Western psychiatry were neurosis and psychosis. Psychosis refers to severe forms of mental disorder such as schizophrenia; neurosis refers to less severe forms of mental illness such as anxiety and depression (Gelder *et al.* 1990). These classifications were included as major subdivisions in the psychiatric chapter of all editions of the International Classification of Disease up until the present tenth edition (ICD10). The ten sections of the psychiatric chapter of ICD10, chapter F, are:

FO Organic, including symptomatic, mental disorders
Fl Mental and behavioural disorders due to psychoactive substance use
F2 Schizophrenia, schizotypal, and delusional disorders
F3 Mood (affective) disorders
F4 Neurotic, stress related, and somatoform disorders
F5 Behavioural syndromes associated with physiological disturbances and physical factors
F6 Disorders of adult personality and behaviour
F7 Mental retardation
F8 Disorders of psychological development
F9 Behavioural and emotional disorders with onset usually occurring in childhood or adolescence

The fact that for many mental disorders no physical pathology can be identified, has been used by critics of psychiatry as evidence that mental illness has no biological basis but is a social fabrication. According to this perspective 'mental illness' is a label that is applied in a given society to people who display certain forms of behaviour that are considered to be abnormal or deviant. 'Mental illness' is understood not as a fixed static biomedical disease entity, but a transient social ascription (Foucault 1967). The most celebrated proponent of this view is Szasz (1972, 1967) for whom the notion of 'mental illness' is a myth.

He aims his criticism at the use of the biomedical model in psychiatry to account for mental illness. The biological approach conceives of mental illness and physical illness as disease entities of the same logical order; the difference being that mental illness affects the brain and results in mental symptoms, and bodily disease affects certain other body organs and results in related symptoms. As Szasz (1967: 250) puts it:

> Some seem to posit that mental illness is a disease entity like an infection or a malignancy. If this were so one could catch or get a mental illness. One might have or harbor it, one might transmit it to others and get rid of it. In my opinion there is no evidence to support this, what people now call mental illnesses are for the most part communications expressing unacceptable ideas, often framed in an unusual idiom.

For Szasz there are two fundamental errors to the biomedical approach to mental illness. First there is the epistemological problem of the distinction of mind and body; mental disease and bodily disease are considered to belong to the same logical category, but the mind and body are not. The second error follows from this, the symptoms of 'mental illness', an abnormal belief, or an unusual behavioural pattern, cannot be allocated to a defect in the brain or central nervous system, in other words they cannot be related to a physical pathology.

To further substantiate his claim, Szasz refers to the element of the biomedical model that defines disease as a deviation from an established norm. As Engels (1977) puts it, the biomedical model "assumes disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables" (quoted in Mishler 1989: 153). Szasz's point here (1967) is that the norm of physical health can be explained in anatomical and physiological terms, but the norm of mental illness must be couched in social, ethical and legal concepts. Thus he considers it 'logically absurd' to use medical treatments for something that is defined using non-medical concepts. Where there is a clear physical pathology of a mental disorder, such as syphilitic infection of the brain, Szasz refers to this as a neurological disease; it is a disease of the brain, not the mind, and as such is in the domain of neurology. Mental illness, the domain of psychiatry, is concerned with problems of living.

Given that there is so little evidence of physical pathology underlying mental illness, psychiatry uses other methods to conceptualise and diagnose it. Another way to define disease is to shift the emphasis from

somatic lesions and focus on deviations from normal physiological and mental functions, as for example with asthma or hypertension. In relation to psychiatry this view goes back to Lewis (1953) who defined mental illness in terms of 'evident disturbance of part function' and 'general efficiency'. On one level the functioning of the brain relates to maintaining healthy physiological processes such as breathing and body movements, but on another level it relates to psychological process such as memory, emotion, thinking and perception. Mental illness can thus be related to disturbance in these psychological functions. It is this approach to mental illness which psychiatrists adopt when they are required to make statements about mental health in connection with legal issues. The problem of this approach to mental illness is, whereas normal physiological functions can be easily quantified, what are considered to be normal psychological functions are partly related to variable cultural factors.

Conclusion

By way of conclusion we can see that the two major theoretical problems of Western psychiatry, the physiological basis of mental disorders, and the mind-body division are not applicable to Tibetan medicine. For Western psychiatry the separation of the mind and body in biomedicine remains an unsolved puzzle. The problem, put succinctly, is if disease is something that occurs in bodies and the mind is something of a different logical order, then there can be no diseases or medicine of the mind. If mind and body are thought of in this way how can they interact and have mutual influence? It is certainly true that with the advances of neuroscience some progress has been made in allocating psychological functions to specific locations of the brain. But this in itself is not an answer to the riddle. So far there have been no solutions, only theories. One such theory is identity theory which goes back to Herbert Feigl (1958). This theory views mental processes as identical to processes in the brain. Another theory is epiphenomenalism which views consciousness as a product of physiological processes (Caston 1997).

In the section on Tibetan medical notions of anatomy we saw that the mind and the body are not thought of as two separate logical cate-

gories, they form two poles of a psycho-physical continuum, and as such are very much in a mutual sphere of influence. It is interesting to note that Tibetan Medicine takes quite the opposite view to epiphenomenalism, following tantric and Buddhist cosmology, physiological processes are a product of consciousness.

We can see from the discussion of patients in Dhorpatan and the Tara clinics that unlike biomedicine and Western psychiatry, in Tibetan medicine notions of anatomy and physiology are not so much concerned with biological substrata but with the functioning of the system as a whole, which is governed by the three humours. Porkert's (1976) comments on the approach taken by Chinese medicine are generally applicable here. In his view this approach involves a perception, which is synthetic and inductive; it focuses on the functioning of the system as whole as opposed to biological substratum. He contrasts this with a Western 'rational' perception of substratums, which is causal and analytic. This approach is typified by biomedicine where the image of the body is one of a complex biological mechanism and the concern is with biological substrata.

We also saw that the notion of disease in Tibetan medicine is not something that is fixed and static, but something that changes throughout the course of the illness and the medication is adapted accordingly. In this respect it would be difficult to find Tibetan categories of mental illness which correspond exactly with the categories listed in the psychiatric section of the ICD10. However, symptoms related to the forms of mental illness in sections F2, F3, and F4 are also characteristic of the Tibetan nosological category of *srog rlung.*

The question also arises when we compare medical activity in Dhorpatan with that in the Tara clinics in the UK, as to the prevalence of *gnod pa* in Dhorpatan and its complete absence in the Tara clinics. Could it be that Tibetan medicine in the Tara clinics is going through the same process of modernisation that Janes (1995) claims to be occurring in the Lhasa Mentsikhang whereby the Buddhist elements of Tibetan medicine are downplayed, and Tibetan disease categories are being transformed into discrete static entities to make them consonant with the disease entity approach of biomedicine? There is enough evidence from the patients described earlier to show that at present the approach to disease in the Tara clinics and in Dhorpatan is to view it not as a static fixed entity but as a process. Certainly, the biggest difference lies in the cultural background of the two patient groups and their

corresponding world-views. It is commonly accepted amongst the people of Dhorpatan that spirits exist and are capable of causing disease and it can be argued that this belief itself generates the reality, and the absence of such a belief amongst the patients in the Tara clinics generates a different kind of medical reality.

When I asked Dr. Dhonden about the absence of spirit caused disease in the UK clinics compared with what I had experienced in Dhorpatan, he replied that he had experienced spirit caused disease in India and Tibet among Tibetan, Nepali and Indian patients but not so far in the UK He said that there may have been some spirit influence behind some of the disorders of patients coming to the Tara clinics, but this is a Tibetan cultural understanding that could easily be misunderstood in the West. He said that somebody becoming possessed by an emotion or a negative mode of thinking could be likened to spirit possession. He did not think that it was always necessary to perform rituals to treat such disorders. Medicine alone could bring back balance and give the person the strength to prevent further 'possession'.

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MAGICAL MOVEMENTS (*'PHRUL 'KHOR*) IN THE BON TRADITION AND POSSIBLE APPLICATIONS AS A CIM THERAPY

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INTRODUCTION

Tibetan traditions have employed 'magical movements' (*'phrul 'khor*) as part of their spiritual training since at least the 10th century, as the texts studied here will attest. Contemporary Tibetans refer to them as yoga or yogic practices,[2] and in the west, particularly in CIM (Complementary and Integrative Medicine), they are considered a 'mind-body technique'. Focusing on the magical movements of the Bon *Great Completeness Listening Transmission of Zhang Zhung* (*Rdzogs pa chen po zhang zhung snyan rgyud*, from now abbreviated *Listening Transmission*),[3] I have two distinct, yet complementary, objectives in this article. One is to present the 'magical movements' tradition in its

[1] I would like to thank Dr. Lorenzo Cohen, University of Texas M.D. Anderson Cancer Center, Houston, Texas, for his assistance in making the clinical research study possible and also for his input on this article. I am also very grateful to Mona Schrempf for her editing; without her dedication and attention to details this article would have not come to fruition. And finally, I would like to thank Frances Garret for her kind proofreading and editing.

[2] It is important to understand that the use of the term yoga, although clearly of Indian origin, has been adopted to encompass practices from various other traditions, including mind-body practices of Tibet and China (see for example the description of 'Taoist yoga' in Paper and Thompson 1998: 89–114). As Eliade states: "side by side with this 'classic' Yoga, there are countless forms of 'popular,' non-systematic yoga; there are also non-Brahmanic yogas (Buddhist, Jainist); above all, there are yogas whose structures are 'magical,' 'mystical,' and so on" (Eliade 1990: 4).

[3] Chandra and Namdak 1968. Usually, this text is translated as 'Oral Transmission', and lately, too, as 'Aural Transmission' (Rossi 1999). I think that 'aural' is a better translation of *snyan* than 'oral', yet 'listening' is less cumbersome and it conveys the same meaning. It is important to note that 'oral' is not wrong either, since it is a tradition that was transmitted orally from the mouth of the master to the ear of the disciple, usually through a bamboo cane. Mullin (1997), probably in order to capture this sense, uses 'whispered tradition'. However *snyan* clearly emphasises the listening part, and thus, at least for now, I will use Listening Transmission referring to the above mentioned text. Also, I chose to translate 'Great Completeness' rather than 'Great Perfection' for the Rdzogs chen school of thought and practice.

historical context and examine how they are practiced as yogic practices among some Bon po lay and monastic communities in exile today. The second objective is to determine the application of *'phrul 'khor* in the West, giving particular attention to the possible physical and mental benefits of using these mind-body techniques as part of a CIM treatment for people with cancer.

DEFINING 'MAGICAL MOVEMENTS'

In an etymological analysis, Namkhai Norbu Rinpoche, one of only a few modern scholars to have written about this category of practices, elucidates the meaning of *'phrul 'khor* both as 'magical' and also as 'machine'. Opting to use its Sanskrit equivalent 'Yantra Yoga' which also serves as title for his book (Norbu 1998), he persuasively describes the body as a machine or a tool that one can utilise to understand one's own nature more clearly. This, he states, is the aim of yoga.[4] I have worked extensively on this topic with the current principal teacher at Menri (Sman ri) Monastery in India, Ponlob Thinley Nyima, who has articulated these semantic connotations further. *'Phrul*, which is usually translated as 'magic' or 'magical', can also take on the meaning of 'machine' or 'mechanics' when combined with *'khor*, as in the compound *'phrul 'khor*—the latter expression is sometimes also written as *'khrul 'khor*, as we will see below. *'Khor* literally means 'wheel' but also 'circular movement' or just 'movement', and thus *'phrul 'khor* is usually translated as 'magical movement(s)' or 'magical wheel'. In this chapter I will use 'magical movements' for both *'phrul 'khor* and *'khrul 'khor*, adding any supplemental information in footnotes as need arises.

The Sanskrit rendering used by Norbu also enriches our understanding of 'magical movements'. Yantra is the equivalent of *'khrul* or *'phrul*, while yoga in Tibetan is *rnal 'byor*, where *'byor* means 'union' and *rnal* means 'natural, unaltered state'. Thus, Norbu asserts that 'magical movement' "is a method for the individual to arrive to his or her natural state or condition by way of using the human body in the same way as a machine that, once set in motion, produces a specific effect" (1986: 85).

[4] Norbu 1986: 85.

Interestingly, Luigi Vitiello, an Italian medical doctor who has worked with Namkhai Norbu and has studied Tibetan medicine, also mentions yantrà in an appendix to his *Introduzione alla Medicina Tibetana* (1983). There he writes that 'Yantra Yoga' can be understood as 'unione atraverso il movimiento' ('union through movement'). Magical movement can be thus understood as a union or combined application of the physical, energetic, and mental dimensions found by using the body as a machine. Performing movements that guide the breath and mind into different areas that are opened and harmonised, leading to a deeper understanding of one's own nature of mind, may be what makes them magical. Vitiello states that he considers 'Yantra Yoga' or 'magical movements' mostly a preventive therapy that can cure or align the disturbances of body, energy, and mind (1983: 24). He maintains that although there are physical benefits of practicing 'magical movement', its ultimate goal is to predispose the mind to meditation. He emphasises the importance of practice, comparing the effect of 'magical movements' in one's mind to the pouring of a bit of cold water in a basin of boiling water (1983: 26). The result is temporary, he adds, and in order to sustain the effect constant practice is essential.

Indeed, this was an important observation made by Tenzin Wangyal Rinpoche to the clinical research study with cancer patients I will describe below. As a Bon po dge bshes and lama living in the West, he was both an inspiration for and consultant to the study. In a meeting with Lorenzo Cohen, principal investigator of the cancer study, and myself, Tenzin Wangyal Rinpoche was emphatic about the importance of informing patients of the need to practice daily and continuously in order to see the effects of these practices. He compared it to taking an antibiotic: a doctor would not say 'take it as often as possible; if convenient take them every day, if not three times a week'. Rather, he or she would insist that the patient take the medicine every day. The approach with 'magical movements' should be the same.[5]

'Magical movement' is a distinctive Tibetan practice of physical yoga in which breath and concentration of the mind are integrated as crucial components within particular body movements. The practices of 'channels and vital breath' (*rtsa rlung*) are sometimes included within 'magical movements', in which case they are called 'magical move-

[5] Personal communication during the 2nd International Congress on Tibetan Medicine, Washington, DC, November 5–8, 2003.

ments of the channels and vital breath' (*rtsa rlung 'phrul 'khor*).[6] Sometimes practitioners engaging in 'magical movements' have performed channels and vital breath practices as a prerequisite. In contrast to the Indian physical yoga, in 'magical movements' the practitioner holds the breath in a specific manner, while the body moves guiding that breath, which in turn guides the mind. Chinese mind-body practices such as Tai chi and Qi gong share with 'magical movements' the aspect of having movement in their postures, although the breath is not held but rather maintained as naturally as possible, more like Indian yoga.[7]

'Magical movements' is more prevalent in the Bka' brgyud, Rnying ma and Bon traditions, although it is found in all Tibetan traditions.[8]

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[6] *Rtsa* (Skt. *nāḍī, sirā, srota* or *dhamanī*) can generally mean 'channels' or 'circulatory channels', and *rlung* (equivalent to Skt. *prāṇa* or *vāyu*) is translated here with "vital breath". Both terms, however, have different meanings and therefore translations according to the context in which they appear, such as medical or religious practice, and there are even further variations among different texts and traditions. As Frances Garrett and Vincanne Adams assert, "[t]he definition and enumeration of the circulatory channels [*rtsa*] is clearly a matter of controversy in medical and religious texts from the origins of these literary and scholastic disciplines in Tibet to present date" (Adams and Garrett forthcoming: 6). I am grateful to Frances Garret for sharing this forthcoming article with me. "The channels are the basis of the circulatory system of winds [or vital breath], blood, and other energies and fluids that connect all aspects of the body" (*ibid.*: 2). Therefore, *rtsa*, depending on the context, is translated as 'veins', 'arteries', 'nerves', and so forth. In the channels and vital breath practices, *rtsa* refers to those channels that carry *rlung*. 'Vital breath' is my current rendering for *rlung*, which in this case is a similar concept to *qi* in Chinese and *prāṇa* in Sanskrit (rather than *feng* and *vāyu* respectively which may take more the meaning of external 'air' or 'wind' or even 'breath' (Gutschow 1997). In other words, in the channels and vital breath practices *rlung* refers to a more subtle energy that circulates within the body (through the channels) but is it is still related to the aspect of 'wind' and also of 'breath'. According to Gutschow the Tibetan medical concept of wind is as fluid and multivalent as the reality which it signifies. In my own research within the context of magical movements of the channels and vital breaths, I still do not feel that I have reached a definite translation for *rlung* that will convey its meaning in a Western language. Therefore, I will use 'vital breath' in this chapter (and I am also considering 'inner breath currents'). As we will see below here, it is interesting to see that the five types of *rlung* mentioned in the Tibetan medical system are equivalent to the five ones used in channels and vital breath practices.

[7] An in-depth analysis of the relationship between the Indian, Chinese and Tibetan yoga would be of great value, however it is outside of the scope of this study. I hope that in the future I can investigate this further.

[8] Tsong kha pa, the founder of the Dge lugs tradition, wrote an important commentary on the famous *Naro'i chos* drug, the *Six Doctrines or Yogas of Naropa* from the Bka brgyud tradition, which includes 'magical movements' as part of the yoga of 'inner heat' or *gtum mo*. Tsong kha pa's commentary is called *A Book of Three Inspirations: a Treatise on the Stages of Training in the Profound Path of Naro's Six Dharmas* (*Zab*

Despite some claims in favor of roots in Indian esoteric Buddhism, its history is yet to be written.[9] Contemporary Tibetan religious scholars describe 'magical movements' practices as dating back to at least the 8th century.[10] Some claim that different kinds of 'magical movements' were practiced much earlier than that. Certainly by the 11th century many Tibetan texts point to the existence of the practice of 'magical movements', especially within the traditions mentioned above.[11] Although more research is needed to examine how this practice was articulated originally and how it changed over time, it is clear that its roots are well established in Tibetan religious traditions that are over a thousand years old.

My research, as mentioned in the introduction, has focused on the *Listening Transmission*, particularly on the chapter *Quintessential Instructions of the Oral Wisdom of Magical Movements* (*'Phrul 'khor zhal shes man ngag*, henceforth referred to as *Quintessential Instructions*).[12] I have also especially consulted the commentary *Magical Movements, Channels, and Vital Breath from the Listening Transmission [of Zhang Zhung]* (*Snyan rgyud rtsa rlung 'khrul 'khor*, henceforth referred to as *Commentary*) written by the famous meditator and scholar Shar rdza Bkhra shis rgyal mtshan (henceforth abbrevi-

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lam na ro'i chos drug gi sgo nas 'khrid pa'i rim pa yid ches gsum ldan zhes bya ba), and according to Glenn Mullin, who has done extensive work on the 'Six Yogas of Naropa' tradition, the Dge lugs school "received its transmission of the Six Yogas primarily from the *Zhalu* (Sakya [*sa skya*]) school" (1997: 14).

[9] There seems to be a general tendency in the academic study of Tibetan Buddhism to see India as the sole source of authority. Many universities name such programmes 'Indo-Tibetan Buddhism', for example. Scholars such as Dan Martin and Toni Huber have pointed out this problem in Tibetan studies (see Martin 1991 and Huber 1994, as well as my own follow-up study in Chaoul 1999). I would like to call attention to the need for more research in regards to the Chinese influence in Tibetan yoga and other Tibetan practices and schools of thought.

[10] Norbu asserts that "the great acarya Vairocana (8th century) developed this tradition of Trulkhor Nyida Khajor or Yantra, known as the Unification of *Sun and Moon*" (Norbu 1998: 11). The extant Tibetan text *'Phrul 'khor nyi zla kha sbyor gyi rtsa 'grel*, henceforth called *Sun and Moon*, contains a commentary by Namkhai Norbu himself (see Be ro tsa na and Nam mkha'i nor bu 1993).

[11] See Mar pa chos kyi blo gros 1995; Vairocana's *Sun and Moon* (Be ro tsa na and Nam mkha'i nor bu 1993); some of the texts related to the *Six Yogas of Naropa*, such as Til lo pa's *Oral Instructions of the Six Doctrines* (*Chos drug gi man ngag*), and Na ro pa's *Vajra Verses of the Whispered Tradition* (*Snyan rgyud rdo rje'i tshig rkang*) — both referred to in Mullin 1997; and, among others, the Bon text that is part of this study (see following paragraph).

[12] For the *Quintessential Instructions*, see Chandra and Namdak 1968: 631–43.

ated as Shar rdza, 1859–1934). The *Commentary* is included within Shar rdza's collection of the *Great Treasury of the Vast Profound Sky* (*Byang zab nam mkha' mdzod chen*), and it is the most widely utilised text on 'magical movements' among present-day Bon practitioners, both lay and monastic.[13] Following on the etymological discussion above, I should note that in *Quintessential Instructions* the term concerned is spelled *'phrul 'khor*, and in Shar rdza's *Commentary 'khrul 'khor* is used. Even when citing from the former, Shar rdza maintains the latter spelling.[14] Ponlob Thinley Nyima, however, favours *'phrul 'khor* as the best rendition,[15] a choice that heightens the meaning of 'magical'.

PRACTICAL APPLICATIONS OF 'MAGICAL MOVEMENTS' AS A MIND-BODY TECHNIQUE

Over the last several years I have expanded my research from the academic to examine the practical and physical applications of these Tibetan mind-body practices and in both Tibetan and Western settings, giving particular attention to the potential benefits of using 'magical movements' as part of CIM treatments for people with cancer in the West. In 2000, together with the principal investigator Maria Alma Rodriguez (M.D.), the psychologist Dr. Lorenzo Cohen, and colleagues Carla Warneke and Rachel Fouladi from The University of Texas MD Anderson Cancer Center of Houston, a randomised controlled clinical trial was conducted to determine the feasibility, acceptability, and initial efficacy of 'magical movements' with cancer patients (see Leon 2003, Cohen et al. 2004).

In comparison, Bon exile lay and monastic communities use 'magical movements' primarily to develop their meditation practice.[16]

[13] For the Commentary, see Shar rdza Bkhra shis rgyal mtshan 1974a: 321–46.

[14] Not only do we see that in the title but in every occurrence of the word (Shar rdza Bkhra shis rgyal mtshan 1974a: 321–46).

[15] Ponlob Thinley Nyima in personal conversations, Houston 2002 and 2003.

[16] This statement is based on my fieldwork data gathered between 1993 and 2001 at the Bon monasteries of Menri in India and Tritan Norbutse (Khri brtan nor bu rtse) in Nepal and among their lay communities. See also Vitiello 1983. In an interview with Menri Trizin Lungtok Tenpe Nyima, abbot of Menri monastery, in February 2002, he mentioned especially a group of female practitioners and nuns from his homeland Shar

Traditionally, the movements are said to strengthen one's physical health and emotional stability as a secondary benefit, and this factor also attracts monastic and lay practitioners. Ponlob Thinley Nyima asserts that Tibetan 'yogis' (*rnal 'byor pa*) or 'accomplished meditators' (*rtogs ldan*) practicing in caves use magical movements to dispel bodily illness as well as other mental and energetic 'obstacles' (*gegs sel*),[17] in addition to using them to enhance their 'meditative experiences' (*bogs 'don*). He adds that these yogis have no access to hospitals or other health care institutions and so it is through these practices that they address their physical and mental health.[18] Clearly, enhancing meditative experiences and dispelling obstacles of mental and physical nature are two main objectives of 'magical movements'. The aim is to be able to integrate those experiences into everyday life or one's 'daily behavior' (*spyod pa*).[19]

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khog (Amdo) who practise 'magical movements'. Whether and how intensively 'magical movements' are commonly practised among Bon monastic and lay communities in Tibet today has to be still clarified through fieldwork.

[17] Although many times written as *bgegs*, in Shar rdza's *Commentary* this type of 'obstacle' or 'hindrance' is spelled *gegs* and in *Quintessential Instructions* as *gags*. Thus far I have not been able to find if there are any significant differences in meaning amongst them or any specific meaning within medical texts. It seems, however, that *bgegs* is utilised more to express obstacles or hindrances provoked by 'demons' or 'malignant spirits' (*bdud, gdon* and so forth), and in conversations with Ponlob Thinley Nyima he would talk of *gegs sel* as the clearing of physical and mental obstacles (that are not necessarily provoked by other spirits). Yet, at this point this remains a mere assumption on my side that needs further investigation.

[18] Ponlob Thinley Nyima, lecture on 'Mind-Body Practices of the Ancient Tibetan Bon Tradition', held at Rice University, Houston, Texas, June 19, 2002. Many times, in conversations with Tibetans, they would speak more about the physical effects of these practices vis-à-vis the solely mental meditative practices that are more common in their repertoire. This, however, does not deny the importance of mind and energy in 'magical movements', and in fact when questioning them further they would say that of course the meditative aspect is crucial but that its uniqueness comes in its utilisation of the body.

[19] I am referring here also to the oral teachings of various Bonpo lamas, including Ponlob Thinley Nyima, and Tenzin Wangyal Rinpoche, and particularly the latter's teachings of the chapter on 'Behaviour' (*Rkyen lam du slong ba rtsal sbyong spyod pa'i khrid*) from the *Experiential Transmission of Zhang Zhung* (*Nyams rgyud rgyal ba'i phyag khrid bzhugs so*), a practice manual that condenses the main practices of the *Listening Transmission*, composed by the 13th century scholar and meditator Dru Gyalwa Yungdrung (Bru rgyal ba G.yung drung). A later chapter of the same text includes in fact the same 'magical movements' as those found in *Quintessential Instructions* (cf. Bru rgyal ba G.yung drung 2002: 253–64).

Based on this premise, and on preceding studies on meditation with patient populations,[20] the M.D. Anderson team created a practical application of 'magical movements' for cancer patients. For this pilot study, we designed a seven-session programme called 'Tibetan Yoga', which included channels and vital breath practices from the *Mother Tantra* (*Ma rgyud*)[21] and the preliminary or foundational (*sngon 'gro*) 'magical movements' cycle as described in Shar rdza's *Commentary*. Our hypothesis was that through the practice of 'magical movements' together with channels and vital breath practices, patients would be able to alleviate the mental and physical stress caused by the severe side effects of cancer treatment, such as chemotherapy or radiation. Details of the study will follow later in this article.

'Magical Movements' in Western Literature and Practice

Although there are only very few scholarly works in English or other Western languages on 'magical movements' in general, and certainly nothing about those of the Bon tradition, Western societies' interest in this more physical kind of Tibetan practice has grown immensely.[22] Norbu's book *Yantra Yoga* (1998) describes the preliminary or foundational set of eight movements in Vairocana's text *Sun and Moon*, writ-

[20] Herbert Benson and Jon Kabat-Zinn have been pioneers in this area; see Benson and Hopkins 1982; Benson et al. 1990; Kabat-Zinn 1982; Kabat-Zinn, Lipworth and Burney 1985; and Kabat-Zinn, Massion, Kristeller, Peterson, Fletcher et al. 1992.

[21] *Ma rgyud sangs rgyas rgyud gsum rtsa 'grel (The Three Basic Mother Tantras with Commentaries). Reproduced from original manuscript belonging to the Samling Monastery (bSam gling), Dolpo, N.W. Nepal* (1971 Delhi, Dolanji: Bonpo Monastic Centre). There is also a later edition from 1985, ed. Tshultrim Tashi, *Ma rgyud thugs rje nyi ma'i rgyud skor*, Dolanji, India: Tibetan Bonpo Monastic Community (TBMC). Kuntu Zangpo (Kun tu bzang po) is considered to be the author of the Root Texts, and Milu Samlek (Rgyal gshen Mi lus bsam legs) the author of the Commentaries. The Terma (*gter ma*) was rediscovered by Guru Nontse (Gu ru rnon rtse) in the 11th century.

[22] During the last three years the *Yoga Journal* published two articles related to 'Tibetan Yoga', the most current one about this particular clinical research study is Solan 2003 (see also Lipson 2000). Also, Snow Lion Publications Newsletter included two articles of my own on *'phrul 'khor* (see Chaoul 2002 and 2001); and an article on the clinical research study's publication in Cancer (Cohen *et al.* 2004). In fact, the publication of that study in Cancer brought significant media attention, including a local newspaper (*Houston Chronicle*) and TV news coverage (Channels 2 and 11) as well as some other journals and newsletters, such as the *News Medical*, *American Cancer Society News Center*, *Florida College of Integrative Medicine News*, and *The Washington Post*, among others.

ten for practitioners.[23] There are few expositions on the famous *Six Yogas of Naropa* (*Naro chos drug*), which, although better known as the *Six Yogas*, should be more accurately called 'doctrines' (*chos*). As Mullin states,

> [e]arly scholars such as Dr. Evans-Wentz, Prof. Herbert Guenther, and Garma C.C. Chang used this rendition in their translations and consequently established it as a standard in the Western Buddhist world.[24]

Mullin maintains that not all lineages among the *Six Yogas* traditions used 'magical movements' and additionally, that the numbers and kinds of physical exercises varied with different traditions.[25] It is primarily those from systems taught by the earlier masters who included the practices, and in such cases they were placed within the inner heat yoga (usually the first, or among the first chapters). Tsong kha pa followed the tradition of Phag mo gru pa, who in his manual *Verses on the Path Technology: a Supplement* (*Thabs lam tshigs bcad ma'i lhan thabs*) describes 'six exercises for purifying the body', which Mullin claims were "famed as the 'six exercises of Naropa'" (Mullin 1996: 134). Geshe Michael Roach, in a book for practitioners called Tibetan Heart Yoga (Roach 2004), has the same six movements 'piggybacked' to Hatha Yoga postures.

It is interesting to note that even those scholars and practitioners who did not include 'magical movements' and the meditation of the body as an empty shell (which tends to be grouped within the *Six Yogas* tradition) still see a benefit in practising them. For example, Ngulchu

23 See Be ro tsa na and Nam mkha'i nor bu 1993. I have heard, however, that Namkhai Norbu and Adriano Clemente are soon to publish the translation of *Sun and Moon* (to be published by Snow Lion Publications, forthcoming 2004–5).

24 Mullin 1997: 13. Mullin refers to the works of the following scholars: Lama Kazi Dawa-Samdup's 1935 translation of the *Naro'i chos drug* with interpretation by Evans-Wentz barely include the 'magical movements' that are part of the inner heat (*gtum mo*) chapter, and in the 1967 edition more explanations by the Chan scholar Garma C.C. Chang are added (Evans-Wentz 1967). Garma Chang, in collaboration with Charles Muses, translated Tsong kha pa's commentary (see Muses and Chang 1961). Mullin then re-translated the latter (Mullin 1996). The noted scholar Herbert Guenther also includes a translation of the 'Six Yogas' in The Life and Teachings of Naropa (1963). In his earlier work Mullin remarks: "Tsongkhapa also points out that there are various ways of counting and structuring the six. In settling upon the arrangement that he prefers, he refers to the writings of the glorious Pakmo Drupa (b. 1110), one of the early lineage masters, wherein the structure is as follows: (1) inner heat; (2) illusory body; (3) clear light; (4) consciousness transference; (5) forceful projection; (6) the bardo yoga" (Mullin 1996: 29).

25 Mullin 1996: 133–34.

Dharmabhadra (Dngul chu dhar ma bha dra), an 18th century Dge lugs pa scholar, wrote:

> When they are performed, there is less chance of problematic side effects arising in the channels or energies through forceful meditation on the tantric yogas; and even if some difficulties do arise, these are mitigated.[26]

Tenzin Wangyal Rinpoche explains the basis of the experiences that arise from these kinds of practices:

> All experience, waking and dreaming, has an energetic basis. This vital energy is called lung [*rlung*] in Tibetan, but is better known in the West by its Sanskrit name prana [*prāṇa*]. The underlying structure of any experience is a precise combination of various conditions and causes. If we are able to recognise its mental, physical and energetic dynamics, then we can reproduce those experiences or alter them. This allows us to generate experiences that support spiritual practices and avoid those that are detrimental.[27]

This is exactly the aim of the 'magical movements' practitioner: he or she wishes to reproduce and alter those experiences through physical movements that guide the vital breath, and this in turn guides the mind, which enables the generation of specific experiences. This description is also in agreement with the above accounts by Norbu and Vitiello. One's physical body, speech or energy, and mind are known in Buddhist Tantric as well as Bon Great Completeness teachings as the 'three doors' through which one can practice and eventually realise enlightenment. The energetic body, represented by the vital breath and the channels, is said to be the link between the mind and physical body, and therefore it can be equated with 'speech'. The 'magical movement' practices assume, explicitly or implicitly, that the practitioner is familiar with channels and vital breath practices. These practices are crucial in the training and harmonising of the channels and vital breath, and this is the basis of 'magical movements'. In the course of the channels and vital breath practices, the practitioner becomes familiar with the channels first through visualisation, and then by being able to use the mind to direct the vital breath along those channels. The mind, as the rider, and the vital breath, as the horse, travel together through the pathways of the channels. Consequently, the channels become more pliable

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[26] From the *Na ro chos drug gi zin bris yid ches dgings rgyan*, cited in Mullin 1996: 259, fn. 30.

[27] Wangyal 1998: 42. He uses 'vital energy' for *rlung*, for what I have been using 'vital breath'.

and the vital breath harmonised, allowing the mind to have a smoother ride. With the help of movements that guide the mind and vital breath into different areas of the body, the practice brings the possibility of healing in body, energy, and mind. In the Bon tradition, the principal text used for the channels and vital breath practices is the *Mother Tantra*, especially the chapter on *'Byung ba'i thig le*.[28]

According to Lopon Tenzin Namdak, the most widely known living teacher, scholar, and Rdzogs chen meditator of the Bon tradition today, 'magical movements' should be used when one's meditation in the natural state of mind is not clear, not stable, or weakened in some way.[29] The practices are an aid for the *Rdzogs chen* practitioner to 'get back', stabilise or clarify her/his meditation in the natural state of mind. In this way, by following the instructions for the physical movements prescribed and holding the breath naturally, the mind is able to rest in its meditative state together with the breath. At the end of every movement, with the exhalation and the sounds of 'ha' and 'phat', the practitioner can cut through any concepts that persist, allowing him or her to remaining more steadily in the natural state of mind. Both *Quintessential Instructions* and Shar rdza's *Commentary* describe the 'magical movements' that are done while simultaneously holding the breath in a natural way (*ma ning rlung*). Holding the breath in this natural way during each whole movement and then exhaling forcefully at the end helps the practitioner to be induced into the natural state of mind.[30]

'Magical Movements' of the Listening Transmission: Organisation and History

There are 39 'magical movements'. These are systematised into four categories, which I will call 'cycles': 'foundational' (*sngon 'gro*), 'root' (*rtsa ba*), 'branch' (*yan lag*), and 'special' (*bye brag*) cycle. Each of

[28] In *Ma rgyud thugs rje nyi ma'i rgyud skor* (Rgyal gshen Mi lus bsam legs 1985: 591–619).

[29] Private conversation, Charlottesville, Virginia, July 2000.

[30] Other kinds of holding are also applied, such as the 'vase retention' (*bum pa can*). This is not so clear in *Quintessential Instructions*; the *Commentary* mentions them by name but actually Shar rdza explains them more fully in the chapter on 'inner heat' (*Thun mong gtum mo'i nyams len ye shes me dpung*); see Shar rdza Bkra shis rgyal mtshan 1974b: 551–97.

these has two sets of 'magical movements', with the exception of the foundational which has only one set, making a total of seven sets. It can be schematised as follows, added by folio numbers in brackets, according to the *Commentary*:

1) Foundational magical movements (323.3)

2) Root magical movements (326.2)
2.a Root (326.2)
2.b [Root magical movements that] Clear away obstacles (330.1)

3) Branch magical movements (333.2)
3.a Root (333.2)
3.b [Branch magical movements that] Clear away obstacles (335.5)

4) Special magical movements (338.3)
4.a Special magical movements that clear individual obstacles away from the head, body, and limbs (338.3)
4.b Special [magical movements] that Clear common obstacles away (340.3)

Five or six[31] masters of the *Listening Transmission* are each known to have designed one or two of the seven sets of 'magical movements'. In brief, the set of the foundational cycle starts training the breath and warming up the body. The root cycle comprises the main or root set of 'magical movements' that are exercised to maintain the natural state of mind or enhance one's meditative state, and the set of 'magical movements' that clears obscurations. The branch cycle is furthermore divided into a root set of 'magical movements' related to enhancing one's meditative state and a set of 'magical movements' to clear the obscurations. Finally the special cycle is divided a little differently, where the first set is composed of 'magical movements' that clear obscurations of different parts of the body—in a way similar to the foundational cycle—and a set of 'magical movements' that harmonise the whole body, speech, and mind by clearing away common obscurations to the whole mind-body system. This is a simplified description of the overall 'benefits' (*yon tan*) of each set. At the end of each set, the texts explain the

[31] Depending on whether we count Yang ston chen po as one who designed part of a set or just transmitted it to his son 'Bum rje 'od, which is what the text says.

benefits of the movements comprised, sometimes as general benefits of the set of movements and other times as the benefit of each of the movements individually.

The teachers and/or compilers of the 'magical movements' from the *Listening Transmission* are mentioned both in the *Quintessential Instructions* and in the *Commentary* as follows:

1. Dpon rgyal btsan po alias Dpon rgyal chen po for the foundational cycle and the root set of the root cycle;
2. Rtog med shig po for the set of 'magical movements' that clear obscurations from the root cycle;
3. Lhun grub mu thur for both sets of the branch cycle;
4. 'Or sgom kun 'dul for the first set of the special cycle; and
5. 'Bum rje 'od for the last set, from which the first three movements were taught to him by his father and famous meditator and scholar Yang ston chen po alias Yang ston Shes rab rgyal mtshan.

All of these figures seem to have had a close, direct teacher-student relationship, except for the case of Lhun grub mu thur and 'Or sgom kun 'dul, in which case it is not clear if they actually had met. However, both are part of the group of five masters of the 'lower tradition' (*smad lugs*) of the *Listening Transmission.* Although it is difficult to date the lifetimes of these teachers, Yang ston chen po is said to have "lived [in] the last quarter of the 11th century".[32] I would assume that Dpon rgyal btsan po's life dates are positioned in the 10th century. 'Bum rje 'od, the last one of these teachers, appears to have compiled all the sets into cycles and put them together as a text. Since he was a direct disciple and son of Yang ston chen po, *Quintessential Instructions* should be placed around late 11th or early 12th century. Lopon Tenzin Namdak and other exponents of the Bon tradition claim that these 'magical movements' as oral and listening transmission date from many centuries earlier, although it is difficult to place them historically or to know what kind of systematisation or curriculum they followed then, if any.

A CIM Application with Cancer Patients

Understanding the main goals of 'magical movements' as the dispelling of mental and physical obstacles, the enhancing of meditative practice,

[32] Karmay 1998: xvii. Karmay adds as supporting evidence for that date, that Yangton Chenpo had studied Buddhism from Bari Lotsawa who was born in 1040 CE

and their integration into daily life, the University of Texas M.D. Anderson Cancer Centre team in Houston began a study with lymphoma patients, applying the seven-week Tibetan yoga programme referred to above, to investigate the potential positive effects on quality of life and well-being.[33] The movements chosen were simple, and yet they constituted complete cycles: they were a complete and sequential ensemble of movements belonging together, arranged from the external practice cycle of the channels and vital breath from the *Mother Tantra* and the 'magical movements' foundational cycle from Shar rdza's *Commentary*.

The channels and vital breath practices use slow physical movements guiding the breath in four steps (inhalation, holding, re-inhalation, and exhalation) in each of the five distinct ways of vital breath (*rlung*), which are also mentioned in Tibetan medical texts: upward moving (*gyen du rgyu*), life-sustaining (*srog 'dzin pa*), pervasive (*khyab pa*), fire equalising (*me mnyam pa*), and downwards and cleansing (*thur du sel ba*).[34] Through these five movements, the *Mother Tantra* explains, the vital breaths circulate into five main energetic centers or chakras (*'khor lo*), i.e., crown, throat, heart, navel, and secret, which are all along the central channel. In essence, through the mind being together with the breath, like a rider on a horse as it is described in the 'Mother Tantra', each movement allows the related energetic centers to open. This in turn allows the mind to abide with less distraction in the different centers and finally in the 'heart-mind' or heart center, which is said to be the abode of the natural state of mind. The foundational set of 'magical movements' is like a massage (or energetic massage) of different parts of the body: head, legs, arms, torso, and lower body, respectively. During each movement the breath is held in a natural way, and this allows the air to pervade the whole body, helping the purification,

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[33] The study was funded by a grant from the Bruce S. Gelb Foundation.

[34] We see the same names used for the five different vital-breaths in different medical texts as well as in various Vajrayana practices, Buddhist and Bonpo. Interestingly however, as Dr. Yeshi Dhonden remarks, the Tibetan medical texts locate the life sustaining vital breath at the crown of the head and the pervading vital breath at the heart, and in the Vajrayana texts this is reversed (Dhonden 2000). Dr. Dhonden adds:

> Moreover, when Tibetans refer to disorders of the life-sustaining wind, we always refer to the heart, which is where such disorders are felt, with symptoms such as heaviness, palpitation, throbbing, and so forth. Thus, even though the medical tantras say it is located on the top of the head, in actual practice Tibetan doctors identify is as being located at the heart. So there is somewhat of an incongruity between theory and practice (Dhonden 2000: 24–25).

nurturing, and healing process.[35] At the end of each of the 'magical movement' one exhales through the nose and continues through the mouth by vocalising 'ha' and 'phat', which helps to remove the stale air. In this way one's mind is induced to be in a relaxed and aware state, with the intention of purifying oneself and all sentient beings. Although the Tibetan texts do not, of course, explicitly mention concepts of stress reduction, the elimination of intrusive thoughts, or improvement of sleep as beneficial outcomes, these and other related outcomes can be included among the secondary benefits related to the clearing away of obscurations.[36] Namkhai Norbu also mentions these outcomes as secondary practices that "help one to approach contemplation...or to achieve some specific aim, such as healing oneself and others".[37]

In the first study of Tibetan Yoga at M.D. Anderson Cancer Center, 39 lymphoma patients were randomly assigned to be either in the Tibetan yoga intervention group or in the wait-listed control group. The former group received the seven-week Tibetan yoga programme, while the latter did not, and measurements were taken on both to see any significant health or behaviour related changes between participants of one group as compared to the other. The control group participants had the opportunity to receive the Tibetan yoga intervention after the three-month follow-up assessment, which is why it is called 'wait-listed'. In order to be eligible, the lymphoma patients had to be currently undergoing treatment or had to have concluded treatment, mostly radiation and/or chemotherapy, within the past 12 months. There was an even distribution of severity of disease between the two groups, and 15 patients in each group were not currently receiving treatment for their lymphoma. Patients of both groups completed self-reported evaluations at baseline (i.e., before they began the programme) as well as one week, one month, and three months after the seven-week programme. The study took almost a year to complete, including patient recruitment at the lymphoma clinic at M. D. Anderson, and their participation in the seven-week Tibetan yoga intervention programmes at the Place of Wellness, M. D. Anderson's center for clinical delivery of complemen-

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[35] This pervasive breath is the same *khyab pa'i rlung* among the five channels and vital breath practices.

[36] Ponlob Thinley Nyima, lecture on Mind-Body Practices of the Ancient Tibetan Bon Tradition, held at Rice University, Houston, Texas, June 19, 2002.

[37] Norbu 1986: 93–94.

tary programmes. Those patients who were randomised to the control group did not participate in the yoga programme during the study. However, both groups completed the baseline and post-treatment assessments at the same time intervals. After completing the study participants in the control group could participate in the Tibetan yoga programme, however no assessments were conducted. We began the seven-week sessions after each recruitment cycle, which took approximately a month each, allowing classes of between four and nine people in each session.

90% of the Tibetan yoga participants completed at least two to three of the Tibetan yoga sessions; 58% completed at least five sessions. Overall, the results indicated that the Tibetan yoga programme was feasible and well-liked. The majority of participants indicated that the programme was either 'a little' or 'definitely' beneficial, with no one indicating 'not beneficial', and that they continued practicing at least once a week, with many continuing to practice twice a week or more.[38] In an interview with Ruth Piana, a patient in this study, a journalist writes,

> the combination of breathing, movement and meditation met a strong need for Piana. 'The beautiful part about the yoga was that it was slow and easy', says Pasadena, a Texas resident. 'It was not fatiguing at all. It was very pleasant, and it helped me get active again'.[39]

It is worthwhile mentioning that none of the patients involved in these studies had any previous knowledge of even the existence of *rtsa rlung 'phrul 'khor*, and the majority of the patients had never engaged in any other meditative or yoga practice before.

The patients in the Tibetan yoga group reported significantly better overall sleep quality and subjective sleep quality, faster sleep latency, longer sleep duration, and less use of sleep medications during the follow-up period than the patients in the control group. Improving sleep quality in a cancer population may be particularly salient as sleep is crucial for recovery and fatigue and sleep disturbances are common problems for patients with cancer. The principal investigator of the study, Dr. Cohen, was optimistic about the results:

> Theoretically, if the Tibetan yoga intervention is found to decrease the

[38] For the complete results of this study, see Cohen *et al.* 2004.

[39] Cited from and in Leon 2003.

patient's stress level, it could, therefore, have an impact on their immune system. There is evidence to suggest that stress suppresses cell-mediated immunity, a component of the immune system involved in tumor surveillance. Yoga might also have an impact on patients' hormonal activity.[40]

CONCLUSIONS

The investigators of this study concluded:

> Although research into the efficacy and mechanisms of yoga is in its beginning stages, the findings reported to date are supportive[41] and, along with our finding of improved sleep, suggest that the health effects of yoga in cancer patients should be explored further. The benefits that have been documented and the potential impact of these benefits on the psychologic and physical sequelae of cancer are important enough to warrant the further study of developing such programs for cancer patients.[42]

These are encouraging signs for the positive effect that 'magical movements' might have, not only as a general method for sustaining health and a steady mind but also for improving well-being for chronically ill populations, such as for cancer patients. These beneficial effects could also be extended to other cancer or medical populations. In fact, a second study is examining the benefits of this Tibetan yoga programme on both psychological and physiological (immune and hormone function) outcomes in women with breast cancer.

These pilot programmes are among the few studies of yoga in a cancer patient population and the only scientific study of 'magical movements' in any population. The fact that the first study was published in a mainstream medical journal such as *Cancer* is another promising sign fostering the inclusion of Tibetan yogic practices within the CIM clinical services and research possibilities.

An important part of this research was the direct involvement of representatives of both the Western biomedical and behavioral sciences communities and representatives of the Bon tradition, thereby integrating the use of the *rtsa rlung'phrul 'khor* transculturally.[43] In the last

[40] Cited from Leon 2003.

[41] Telles and Naveen 1997.

[42] Cohen *et al.* 2004: 2259.

[43] Interestingly too, some Tibetan doctors are still today engaged in practicing *rtsa rlung 'phrul 'khor*. According to Mona Schrempf's recent research with Tibetan doctors in Nag chu (TAR), a particular doctor who also happened to be a Bon po monk

couple of meetings, attended by both Dr. Lorenzo Cohen and Tenzin Wangyal Rinpoche, we began exploring research tools that could assess not only what is interesting from the biomedical and behavioral scientific approaches, but also whether the benefits mentioned in the 'magical movements' texts can actually be proven to be true outcomes for these cancer patients. I consider this kind of interaction and mutual participation an important step towards a more integrative model of applying Tibetan traditional modalities of healing together with Western science and research methods.[44]

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used *rtsa rlung 'phrul 'khor* practices as a kind of health practice. He had learnt it from an 'accomplished master' (*rtogs ldan*) and was initiated into it (through *dbang, lung* and *khrid*). He emphasised that *rtsa rlung* is good to balance all five types of 'winds' (*rlung*) and that its effects are purifying (Schrempf in personal communication). The potential practice of *rtsa rlung 'phrul 'khor* within the Tibetan medical community is another very interesting subject that I hope to explore further in the future.

[44] A pioneering effort in this matter is the work of the Life-Mind Institute, particularly their conference on Investigating the Mind at MIT University, Boston, MA, September 2003. At that time clinical research was presented and opened the dialogue amongst Western researchers, Buddhist scholars and practitioners, and the presence and input of His Holiness the Dalai Lama, raising the importance of this kind of collaboration to both scientific and public awareness. Furthermore, the study presented by Richard Davidson during that conference was recently published in the *Proceedings of the National Academy of Science* (Lutz *et al.* 2004).

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PART FOUR: HISTORY OF TIBETAN MEDICINE

AN EARLY TIBETAN HISTORY OF INDIAN MEDICINE

DAN MARTIN

What follows is basically a report on the authorship and content of a very significant manuscript containing two closely related medical writings by the same author found in the Giuseppe Tucci collection in Rome (Rossi-Filibeck 2003: no. 1281). I would like to thank Elena de Rossi-Filibeck and others who made it possible to obtain a copy of this manuscript in microfilm form. I imagine, even in the absence of specific information, that it was probably procured during Tucci's main expedition through western Tibet and Ladakh in 1935. Although this may be proven wrong, I do not believe Tucci mentioned it in any of his publications—he never seems to have taken a particularly strong interest in Tibetan medicine—although he did include a very brief sketch of medical history in his book *To Lhasa and Beyond* (1956: 99) telling also how a Tibetan doctor in Lhasa cured his feverish bowel complaint using herbal pills.

When preparing the bibliography entitled Tibetan Histories (Martin 1997), I was aware of a great many titles of *khog 'bugs* genre texts that are listed here and there in medical works (*khog 'bugs* texts may be general histories of traditional arts and sciences, and not specifically of medicine). However, I included only those that I felt reasonably sure had circulated in the past. We should distinguish, too, between medical histories that are extant and those which are published. Among the earlier medical histories, some are certainly extant, although not available, or at least not without considerable effort. Among these is the history by Brang ti Dpal ldan 'tsho byed whose present existence was signaled by Kurtis Schaeffer (1998). Of the 48 folios of the extant manuscript, 28 folios are actually on the history of medicine. This probably belongs to the early fifteenth century, as Schaeffer suggests. Another is the medical history by Zur mkhar Blo gros rgyal po—author of the well-known commentary on the *Four Medical Tantras* (*Rgyud bzhi*) called *Ancestral Advice* (*Mes po'i zhal lung*)—which was written in about the middle of the sixteenth century.[1]

[1] Martin 1997: no. 172. The 2001 publication of his historical work has only now become available to me.

If we were to compile a complete list of medical historical works, both available and potentially available, it would be quite long. So it may not be so surprising that, apart from my own bibliography (Martin 1997: no. 36), I have only located one previous listing of the title of our manuscript in a source not in Tibetan language, and that is in Manfred Taube's study of Tibetan medical historical literature (Taube 1981: 65). There is also a brief mention, without supplying the title however, in Rechung Rinpoche's wellknown book Tibetan Medicine (1976: 19). This history is obscure, to be sure, but I believe that there are good reasons why it should and will become better known. The first and simplest reason is that it may be the second oldest Tibetan medical history extant. It could even be the earliest extant, if G.yu thog Yon tan mgon po the Younger did not really write the *Khyung chen lding ba* in the form in which we have it, as Samten Karmay has suggested (1989: 22). Still, there is always a strong element of risk involved when speaking of firsts in history, all the more so since various eleventh- and twelfth-century figures are said to have written *khog 'bugs* texts.[2]

To begin with, we should remark on the physical condition of the manuscript, before addressing particular questions relative to its authorship, dating and content.

A. *The manuscript*

Having only a black-and-white microfilm upon which to base judgment, it will not be possible to be very specific. From the catalogue we may know that its leaves are long and rather unusually narrow, measuring 10 by 60 centimeters. It is written in two kinds of metallic ink, most probably silver and gold, on paper completely covered with dark, probably dark blue or black, sizing. The first text, in 46 numbered folios, bears the title *Sman gyi byung tshul khog dbubs rgyal mtshan rtse mo 'bar ba*. The second text, in 8 folios, is just an outline of the first, and will not receive much attention here. There are two very fine line drawings on the verso of the title page: on the right side of the page, Āryadeva, and on the left, Ācārya Śūra (which in this context must be understood as one of the very many names of Vāgbhaṭa[3]). The script is a

[2] Sde srid Sangs rgyas rgya mtsho mentions some of these early works, which for most part he was unable to inspect personally (1982: 568–69).

[3] Che rje's history, at folio 15 *verso*, gives a list of about twenty-one names, which is quite close to the list in Sde srid (1982: 146).

clear cursive, with only occasional abbreviations and unusual spellings. The main problems in reading the microfilm are in the relatively few passages done in golden ink, which at times may be difficult to make out. The final page of the longer text, which contains the main colophon information, is unfortunately the least legible. This is not at all uncommon, since the outer pages of Tibetan books are the ones most liable to get worn from handling and wrapping. It is quite difficult, for the time being, to come to any conclusions about the age of the manuscript. At least we may be absolutely certain that it is not the author's original autograph, since near the end of the longer text is a note saying that a page of the manuscript from which our manuscript was copied was missing.

B. *Authorship*

I could not locate, with any great assurance, the name of the author in the colophon of the longer text since, as noted, the colophon is hard to read. However, while the place of composition is partly visible (the name of the area La stod appears) the date is clearly visible. Perhaps only because I think it should be there, I imagine I can just barely make out, immediately after the date, the name Zhang ston Zhig po. Perhaps an inspection of the manuscript itself would in some part solve the problem of reading the main colophon.

The shorter text, which is an index to the longer one, has a clear but very very short colophon, which just says it was prepared by one Ni yu ta ka ṛu na pra bha ba. This Sanskritised name, also, can only be interpreted accurately with prior knowledge of who the author ought to be. We can see that *karuṇa* corresponds to *thugs rje*, 'compassion', and the *prabhava* (a slight mistake for *prabha*) corresponds to *'od*, 'light', in the name of Thugs rje khri 'od. The word *ni yu ta* is a bit more problematic, but knowing what it should say, it must be corrected to *ayuta*, Sanskrit word for 'ten thousand', and so corresponding to the *khri* in Thugs rje khri 'od. Hence, the name of the author supplied in the index is explainable as a Sanskritised form of the Tibetan name Thugs rje khri 'od.

For further verification on authorship, we may refer to folio 22 *verso* of the main text, which says "I myself composed the *Bdud rtsi'i thigs pa*". Some works on Tibetan medicinal history confirm that this title is among several authored by Che rje Zhang ston Zhig po Thugs rje khri

'od.[4] Furthermore, the author supplies his own medical lineage, ending in "myself, Zhang ston". So I think the Tucci manuscript is, beyond the least shadow of a doubt, the very same medical history by Che rje known to later literature, including the medical history by Sde srid Sangs rgyas rgya mtsho, which made use of the text, and even supplies a rough outline of its content (Sde srid 1982: 568).

I have located several twentieth-century accounts of the life of Che rje,[5] but basically they are all derived from (and sometimes slightly distort) a passage in the famous medical history by Sde srid Sangs rgyas rgya mtsho (1982: 178–79). I translate the part which follows the lineage account as follows:

> One numbered among the group known as the Ten Predecessors Equal to Medicine Buddha, by name Che rje Zhang ston Zhig po, or Thugs rje khri 'od, requested [medical training] from the three [doctors just mentioned] and became fully accomplished in medical treatments. He composed the following works: [1] *Shes bya spyi'i khog 'bugs rgyal mtshan rtser 'bar.* [2] *Sa bcad don 'khrigs 'byed pa'i lde mig.* [3] *Dka' tshoms [~Bka' tshoms] gegs sel gnam lcags 'khor lo.* [4–5] *Tshig don zhib rgyas su 'brel ba mu tig gi 'phreng ba,* both an extensive and an abbreviated version. [6] *Lag len smar khrid [~dmar khrid] rgan mo'i mdzub tshugs kyi tshul du 'chad pa bdud rtsi thigs pa,* written for the sake of Zhang ston 'Dul ba of Skyid smad Khol ma and others. [Short title: *Bdud rtsi thigs pa.* This work surely predates the medicine history, which cites it.] He added fine *mchan* notes to the [main medical] texts. His disciples were several, including Bde ba dpal, Yon tan rgya mtsho and Gtsang ston Dar ma mgon. Dar ma mgon po composed the *Zin tig* for the sake of his students, and for the sake of his sons, the *Yang tig,* which settled ideas about medical procedures. Their lineage holders were known to be many in the circle of the Rog tsho in Bo dong.[6]

Parts of this passage require some comment. The *Zin tig* and *Yang tig* mentioned here, composed by Che rje's student Gtsang ston Dar ma

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[4] For a list of these compositions, see Bla ma skyabs 1997: 180 and Sde srid 1982: 178. It is a matter of regret that I have been unable to recover much positive knowledge of Che rje Zhang zhig's life. We do know that the hereditary lineage of physicians to which he belonged (see Figs 1 and 2) was closely attached to the Western Tibetan court, and even intermarried with the royal family. On this point see Vitali 2003: 74–75.

[5] Pa sangs yon tan 1988: 46–47, Byams pa phrin las 1990: 90, Dkon mchog rin chen 1994: 49, Bla ma skyabs 1997: 180–81, 233.

[6] Rog tsho here possibly refers to a monastery in Gtsang Province named Rong tsho Chos sde Bsam grub bde chen, on which see Sde srid 1960: 203.

mgon po, have been published in reprint editions (Gtsang stod 1975, 1976). These works preserve Che rje's more practical medical instructions, and for this reason among others should prove worthy of close study, both in their own right and as part of the history of transmission of the *Aṣṭāṅgahṛdayasaṃhitā*. The mention of *mchan*-notes is interesting, since we do have an anonymously annotated version of Vāgbhaṭa's work. It is possible that these annotations in whole or in part could be by, or owe something to, Che rje (Vāgbhaṭa 1985).

We may know, by the way, from the main text that he was a follower of the Rnying ma school, since he gives a brief outline of the Nine Vehicles. I don't find this at all remarkable, that a Rnying ma pa would be in a lineage descending from Rin chen bzang po, since medicinal science has always crossed sectarian lines with ease. G.yu thog pa the Younger, who is usually considered a Rnying ma pa, held still another medical lineage that came from Rin chen bzang po.

C. *Dates*

From this history, we discover the date of Lo chen Rin chen bzang po's and the Kashmiri Janārdana's joint translation of the *Aṣṭāṅgahṛdayasaṃhitā*. It was a Wood Hare year, which must be equivalent to 1015 of the Common Era. This translation was accomplished at Tho ling with financial support to the amount of 100 *srang* of gold from Byang chub 'od,[7] with additional funding from a group known as the Four Doctors of Purang. From the sketch of the lineage (see Figs 1 and 2), which includes the names of the Four Doctors of Purang, we know that six generations separated the year 1015 from the author. Calculating about 30 years per generation, this would roughly place Che rje's teaching activities in the decades surrounding the year 1195. One modern work does venture to give him an approximate birthdate in the late twelfth century. Now, since the main colophon supplies a clearly legible sixty-year cycle date, a Wood Mouse year, we might provisionally accept that the date of composition was 1204 CE. At the same time, I have sought evidence within the body of the text to disprove this date, but so far without success. Searching out information about all of the Tibetan fig-

[7] Byang chub 'od's dates ought to be 984 to 1078, according to Vitali (1996: 146). Rin chen bzang po spent 13 years in Kashmir and north India, from 975 to 987. The two other trips he made to Kashmir (dates uncertain) lasted a total of about ten years (Tucci 1988). He died in 1055.

ures mentioned in the text, none lived more than a few years into the thirteenth century. Still, we cannot with complete confidence exclude the date 1264. I think further illumination about the dating will have to wait for a close inspection of the worn last page of the actual manuscript (there are clearly some names that cannot be entirely made out here as well as in the single line of tiny letters following the colophon). Meanwhile, we may use the date 1204 as a working hypothesis, or a disprovable hypothesis if you prefer.

D. *Content*

This history may be characterised as a history of Indian medicine, and for two reasons: First, because most by far of the historical material it contains is in fact about India, and more specifically about Vāgbhaṭa and immediate circle. Secondly, because even in the brief parts that concern Tibetan or other non-Indian medical traditions, the Indian medical system of Vāgbhaṭa, as transmitted in Tibet, is what above all interests the author. I could locate no mention at all of the *Four Medical Tantras* (this statement will be slightly qualified below). This confirms something that we ought to know anyway, which is that during the first two centuries of the 'later propagation' (*phyi dar*), the *Aṣṭāṅgahṛdaya-saṃhitā* of Vāgbhaṭa and closely associated texts, either translated or revised by Lo chen Rin chen bzang po and Janārdana, had the greatest influence until the *Four Medical Tantras* gradually gained center place during the course of the thirteenth century. According to the usual but not universally accepted wisdom, the medical tantras were taken from concealment by Grwa pa Mngon shes in decades surrounding 1100, but only started to become gradually well-known with G.yu thog pa the Younger and his students in the decades surrounding the year 1200.[8]

The larger part of the medicine history is devoted, as I said, to Vāgbhaṭa. Che rje's account of Vāgbhaṭa was in fact the most important (but surely not the only) source for Sde srid Sangs rgyas rgya mtsho's chapter (1982: 127–47) on Vāgbhaṭa in his own medical history.

Che rje proceeds quite slowly, topic by topic. He is quite an orderly, systematic and concise writer, who obviously received some training in

[8] For early Tibetan controversies about the sources and origins of the *Rgyud bzhi*, see Karmay 1989.

philosophical logic. Frequently he even resorts to the scholastic method of ordering arguments known as *gag gzhag spang gsum*, on which Christopher Beckwith (1989) has written a study. And all the while he never loses sight of his main object, which was to write a major analytical study of the *Aṣṭāṅgahṛdaya*. Alas, this ambitious plan was never to be fulfilled. His commentary never gets beyond commenting on the title and the opening homage prayer (while his commentary on the first chapter is certainly outlined in the shorter text, the corresponding commentary itself is not to be found).

But now I would like to concentrate on a rather uncharacteristic passage which forms part of an attempt to draw out a 'universal' history of medicine. It is important to see this passage in its larger context, however. The only reason Che rje tells this universal history is in order to better situate the work of Vāgbhaṭa within the various categories so formed. After a quite significant discussion of the five traditional sciences, Che rje starts to narrow his focus once again on medicine. Here he draws out an outline of four major categories, each with its own subcategories, into which he will eventually place the *Aṣṭāṅgahṛdaya*. These four are:

1. The Seven Schools. We will return to this.

2. The Four Cycles. These are: Outer textual items of knowledge, Inner advice about the meaning [of the text], Secret procedural guidance, and Super-secret experiential guidance.

3. The Four Translations. These are highland, lowland, southern and northern. Che rje adds a brief geography here, about the Five Great Countries: China in the east, India in the south, Stag zig in the west, and Ge sar in the north, with Tibet as the fifth Great Country in the centre. He says that India and China, being fonts of the sciences, were the main sources for many translations, that the Buddha's compassion manifested medical treatments in every country, that during the time of the expansion of the Tibetan kings' domains, they were all translated into Tibetan.

4. The Two Times of Translation. These are, of course, the earlier translations (*lnga 'gyur*, a careless spelling for *snga 'gyur*), and the later translations. Included among the medicine text translators of the later period are not only Rin chen bzang po, but also Skyes bu Me lha,[9]

[9] Skyes bu Me lha's biography is in Bla ma skyabs (1997: 23–24), according to which he was banished from O rgyan to Tibet in the time of Rtse lde. See also Taube 1981: 74 n. 268 and Dpa' bo 1986: 1520.

the Red Ācārya[10] and one named Be nag Brag 'khar ba (the latter did his translations from Chinese).

At the end of this discussion, the *Aṣṭāṅgahṛdaya* is placed within each of the four major categories: Of the Seven Schools, it is the School of the Scholars of the Five Sciences. Of this school's ten systems it is the system of Glorious Pha gol (here a name for Vāgbhaṭa), and of the four texts by Vāgbhaṭa we are concerned with the *[Aṣṭāṅga]hṛdaya-saṃhitā*. Of the Four Cycles, it is the cycle of outer textual items of knowledge. Of the Four Translations, it belongs to the Highland Translation, and of the Two Times of Translation, it was done in the time of the later translations.

Now I would like to draw special attention to the list of the Seven Schools. I suggest first of all that the list is arranged in a deliberately descending hierarchy, placing the Bodhisattvas before the Indian gods and *ṛṣis*. Number 4, the 'Phags pa school, may refer to Buddhist saints in general, but here it means Nāgārjuna in particular. Ordinary humanly created schools of medicine begin only with number 5, covering the countries surrounding Tibet, although China and Tibet get their own separate schools, numbers 6 & 7.

The Seven Schools (Lugs bdun; fols. 21r–22v):

1. Rgyal sras Byang chub sems dpa'i Lugs (Bodhisattva School).
2. Lhas Mdzad pa'i Lugs (School of [Texts] Made by Devas).
3. Drang srong gis Mdzad pa ([School of Texts] Made by Sages [*ṛṣi*]). The eight sages who taught the Caraka texts (*Tsa ra ka Sde Brgyad*).
4. 'Phags pa'i Lugs (Buddhist Saint School). Nāgārjuna's medical texts and commentaries on the same.
5. Mkhas ldan Mnga' Rig[s] gi Lugs (School of the 'Scholarly Powerful Families' [?], but they are later referred to as Lnga Rig pa'i Mkhas pa, 'Scholars of the Five Sciences').
   [1a] Slob dpon Dpa' bo [Ācārya Śūra, here meaning Vāgbhaṭa] composed four texts (titles listed).
   [1b] Brtan pa'i blo gros [Sthiramati] composed *Dri ma med pa'i* [xxx], etc. Kashmiri (Kha che) System.[11]
   [2] Dzi na mi tra [Jinamitra] composed *Gso ba stong dgu bcu rtsa gcig*, etc. Orgyan (U rgyan) System.

[10] 'Gos Lo tsa ba 1976: 697, 1049–50.

[11] I believe the intention is that we should take both Vāgbhaṭa and Sthiramati as representatives of the Kashmiri System. The work by Sthiramati mentioned here seems also to be known by a short title *Dri med gzi brjid*, the one that was composed by "bStan pa'i bLo gros" "in Eastern India" (Rechung 1976: 16). A number of Indian and Tibetan figures were known by the name Sthiramati (or its Tibetan forms Brtan pa'i blo gros or Blo gros brtan pa), and the problem is far too complicated to solve with a brief footnote.

[3] Pra a nan ta [Śrī Ānanda in Sde srid's history] composed *Gnas 'gyur gsum* ['Three Transformations in the Situation'], etc. Magadha (Dbus 'gyur 'chang) System.[12]
[4] Su ma ti kirti [Sumatikīrti] composed *Bsdus sbyor gsum* ['Three Abbreviated Preparations'], etc. Newar (Bal po) System.
[5] Ur pa ya [?] composed *Chos 'byung drug*, etc. Arabo-Persian (Stag gzig) System.
[6] Rdo rje 'bar ba composed *Mi 'jigs pa'i mtshon cha che chung*, etc. Dolpo (Dol po) System.
[7] Legs pa'i rgyan composed *Ga gon gyi rdol thabs su[m] bcu rtsa lnga* ['Thirty-five Methods for Spontaneous Emergence of Ga gon'], etc. Uighur (Hor) System.[13]
[8] Brtson 'grus snying po composed *Sum khugs*, etc. Tangut/Xixia (Me nyag) System.
[9] Rgyal ba'i rdo rje [Jinavajra or [Vi]jayavajra??] composed *Yan [lag] bdun pa*, etc. Khotanese (Li) System.
[10] Btsan pa shing la ha (Tsan pa shi la ha) composed the *Tshad pa'i 'gros 'ded*, etc. Phrom ('Brom, sic) System.

6. Ha shong gi Lugs (School of the [Chinese] Hoshangs). Names mentioned here: Ha shong Ma ha yan & Li ga zin ta.
7. Rigs ldan Bod kyi Lugs (School of Worthy Tibet[ans]). Names mentioned here: Yid 'ong legs pa'i rgyan, Zhang Gzi brjid 'bar, Gyong sman Phan ne [I read Gong sman Phan ne, which would be an 'endearing' yet respectful form of the name of the author's medicine teacher], and 'myself'.

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12 As Verhagen (2002: 144) has succinctly shown, Magadha is considered an abbreviated form of Madhya-gata-dhāra, which explains the Tibetan translation Dbus 'gyur 'chang (compare Hamm's 1960 attempt to explain Madhyadeśa).

13 Lde'u (1987: 299) tells how, during the reign of Emperor 'Dus srong (685/6–704 CE), the areas of Hor and Ga gon were conquered. Christopher I. Beckwith, in an electronic mail communication (December 26, 2003), told me he believes Ga gon would refer to one or another Khaganate north of Tibet, perhaps bordering on the territory of the Uighurs (Hor). Uebach (1990: 402) gives a number of mentions of the country Ga gon, but without offering a definite identification. While *ga gon* could be name of a type of cucumber, as a personal name (in Sanskrit Trapusa), it belonged to one of the two merchants (the other named Bhallika) who met the Buddha soon after His Enlightenment. Here, however, it is clearly a place name, which we can also locate in a Bon text. The country (*yul*) Ga gon appears in a very interesting Bon scripture; see *Khri rje lung bstan gyi mdo*, contained in: *Mdo phran nyi shu rtsa gcig pa* (a collection of hitherto unpublished Bonpo canonical works from the sūtra [mdo] section of the Bonpo Kanjur, reproduced from a rare manuscript from Hor Ba chen Klu phug Bde chen g.yung drung gling), Tibetan Bonpo Monastic Centre (Dolanji 1985), pp. 1–84, at p. 26. By the way, I believe that the syllable *yul*, coming before rather than after the proper name, is acting as a specifier, precisely because we might otherwise expect it to be referring to some other kind of thing (the person or the vegetable).

One general but essential point is that Che rje unfortunately doesn't supply any time frame for the Ten Systems, although we might infer from his statements elsewhere that some or all of these foreign systems might have been introduced during the time of Tibetan imperial expansion, meaning before the middle of the ninth century.[14] But when we investigate more closely, it surely seems that some of the persons named are as late as the end of the eleventh century. We might think that number 2 in the list, Jinamitra, would be the Kashmiri pundit Jinamitra active in Tibet in the first decades of the ninth century, whose name is preserved in numerous translation colophons (some Tibetan histories place his activities in the reign of Khri Srong lde btsan [CE 756–797], but this is probably incorrect; the supplement to the *Sba bzhed* says he was invited by Ral pa can who reigned from 815–838). Given that a doctor from Orgyan who was active in Tibet in the time of the western Tibetan king Rtse lde, one named Skyes bu Me lha (aka Bha ro Lag rdum), was a son of a physician named Jinamitra, we tend to think that this Jinamitra from Orgyan must have lived in the tenth or early eleventh, rather than the early ninth, century (Vitali 2003: 75–76).

Number 4, the Sumatikīrti who represents the Newar system very probably is the same Newar of that name who worked together with the translators Mar pa Do pa and Rngog Blo ldan shes rab in the last part of the eleventh century.

About the others, we should only point out that no. 10, Tsan pa shi la ha is one of the main subjects of Christopher Beckwith's important paper, "The introduction of Greek medicine into Tibet in the seventh and eighth centuries". He is generally agreed to have been appointed court physician to Emperor Khri srong lde btsan. He apparently arrived in Tibet toward the middle of the eighth century by way of China. An early history, one that was not yet published when Dr Beckwith wrote

[14] The brief medical history contained in Dpal 'byor bzang po (1985: 191–97), composed in 1434, is worth comparing. He places a number of local and foreign translators of medical texts within the reign of Khri srong lde btsan: the Indian Śāntigarbha, the Chinese Ha shang Mahāyāna, the Newar Dānaśīla, the Turk Seng mchog chen po, Btsan pa shi la of Khrom, and Khyi ma ru rtse of Dol po (191–92). On the following page, as part of an outline that very much resembles that of Che rje (and probably derives from it in some way even while differing in content, as does the nearly contemporary section 80 in chapter 10 of Don dam smra ba'i seng ge [1976: 460–65]), he lists thirteen schools, those of: India, Kashmir, Nepal, Qarluq, Khrom, China, Zhang zhung, Turks (Dru gu), Mongolians (reading Sog po for Srog po), Mon, Tangut (Mi nyag), Tibet and Rdo[x] (*lacuna*; perhaps Rdol or Dol po?). Compare similar lists, based on other sources, in Taube 1981: 10–15.

his paper, confirms that one Be ci Btsan pa ha la translated medical texts during the 712–755 CE reign of Mes ag tshoms (Lde'u 1987: 300).

About number 5, neither Beckwith (1979: 306) nor I have arrived at any likely conclusion about who Ur ba ya/Ur pa ya might be. However, there are some ideas that could be considered, as a testable hypothesis, even if only to be then rejected. The *Chos 'byung drug* (Six Phenomena Origins) attributed to Ur ba ya, and the *Dbye ba drug* (Six Divisions) attributed to Tsan pa shi la ha, could have as their main subject matter the 'Six Necessities' of early (Greek inspired) Islamic medicine and Indian Unani.[15]

So, in general, we may date Tibetan knowledge of the Ten Systems of Che rje's list to a period spanning the eighth and eleventh centuries. Che rje has nothing at all to say about the medicine in use in seventh-century Tibet. It is also interesting to observe that Sde srid Sangs rgyas rgya mtsho in his medical history (p. 176) also has this list of Ten Systems (leaving off Vāgbhaṭa, and with some mostly minor differences in readings). Although he attributes this to "some people of earlier generations" (*snga rabs pa kha cig*), it is clear that he is quoting, as he does explicitly elsewhere, Che rje's history. This is clear because he supplies not only the list of Ten Systems, but also the immediately following part of Che rje's history on the Four Cycles. I would like to suggest that, while there are other narratives about foreign medical systems active in imperial Tibet (particularly in the late biography of the Elder G.yu thog pa translated in Rechung Rinpoche 1976: 202 ff), the present list ought to be awarded a certain precedence, given the age of the text in which it is found.

One of these other narratives, set in the eighth century, involves nine boys chosen from among the royal subjects of Khri srong lde btsan for their intelligence, who were made to study medicine.[16] This has clear analogies in the nine intelligent boys chosen, during the same time, to

[15] The six necessities (*sittah ḍarūriyyah*) are: climate, diet, bodily rest (and exercise), sleep, degree of emotional calm and excretions (and their retention); see Nasr 1976: 162, for example. Islamic medicine evidently derived these from the Greek medicine of Galen, and via translations of Islamic medical works, they were well known to medieval European Galenic medicine. As some relevent early Tibetan medical texts have surfaced recently (see paper by Yangga given at the Xth International Association of Tibetan Studies seminar, Oxford 2003), it may soon prove possible to prove or disprove this hypothesis.

[16] See Taube (1981: 15–16), who bases himself on the *Mkhas pa'i dga' ston* and on Rechung Rinpoche's book, but see also Sde srid 1982: 174.

learn translations, a list called 'The Nine Great Translators.' It is quite obvious that some of the figures in the list of nine doctors belonged to the eleventh and twelfth centuries, and not to the eighth. Among them is one named Che rje or Cher rje Zhig po, who I suggest is none other than our history writer Che rje Zhang ston Zhig po, transferred, like some of the others very clearly were, back to the imperial period. Christopher Beckwith translates the following words, to the same effect, of the nineteenth-century leader Kong sprul:

> ... although they [the learned scholars] relate how the Nine Learned Tibetan Doctors appeared at the time of the religious kings, it is quite wrong, since they mostly appeared in the time of the later propagation of the [Buddhist] doctrine.[17]

E. *Conclusions*

I would like to close with some considerations on the relationship between the *Aṣṭāṅgahṛdaya* and the *Four Medical Tantras*. In the Norway catalogue of the Bon scriptures just published in Osaka is a chart demonstrating the extremely close correspondence between the chapter titles of the *Four Medical Tantras* and the medical scripture of Bon, the *'Bum bzhi* (Martin *et al.* 2003: 107–23). But I would like to suggest that it is not enough to compare and award priority to one or the other text. Both texts must also be closely compared with the Tibetan translation of the *Aṣṭāṅgahṛdaya*. Some of the work of comparing the *Four Medical Tantras* with the *Aṣṭāṅgahṛdaya* has already been done by the late Ron Emmerick, who has shown beyond any doubt that parts of the *Four Medical Tantras* are to be explained as nine-syllable versions of the seven-syllable verses of the *Aṣṭāṅgahṛdaya* (Emmerick 1977; Taube 1980: 298). I would hasten to add that he was not the first to make this observation. Sog bzlog pa (1975: 217–18), about 400 years before Emmerick, said just the same thing, and gave one example, commenting that there are many more. At the same time, Emmerick has shown that some parts of the *Four Medical Tantras*, including the chap-

[17] Beckwith 1979: 306. Centuries before Kong sprul, Dpa' bo expressed essentially the same idea, that these nine doctors were not in fact contemporary with the Dharma Kings, but emerged gradually in later history (1986: 1525). Perhaps needless to tell for most contemporary historians of Tibet, Tibetan history writers of the past were often critical of their sources, and puzzled over how they ought to be read, much as we do in this paper. Their works therefore do not necessarily deserve to be lumped together and dumped into the polemical category 'historiography' any more or less than do the writings of modern Tibetologists.

ter on pulse diagnosis and a section on 'human conventions' (*mi chos*), are not to be found in the *Aṣṭāṅgahṛdaya*, which therefore cannot be viewed as the exclusive source.[18]

Among the various theories about the origins of the *Four Medical Tantras* held by Tibetan thinkers of the past, the most influential one among the more critically minded is: that a basically Indic text underwent heavy editing by G.yu thog pa the Younger, but since he was identical to the Medicine Buddha, the altered text remains Buddha Word; it merits the status of a scripture. I would argue that the primary candidate for the original Indic text would have to be the *Aṣṭāṅgahṛdaya*. Emmerick's studies in particular point in this direction. Che rje's medical history is instructive, too, since it is entirely centered on the *Aṣṭāṅgahṛdaya*, knows nothing of the *Rgyud bzhi* as such, but is quite aware of Tibetan-authored commentaries on the *Aṣṭāṅgahṛdaya*, including one or more by the school of G.yu thog pa the Younger and his teacher (and, by the way, Che rje knows nothing of a G.yu thog pa the Elder). Other commentators whom he finds worthy of mentioning, since he disagrees with their methods of outlining, are:

1. Dge bshes Mi nyag, who must be Mi nyag Rong rje,
2. Sam bu Lo tsā ba, elsewhere known as a teacher of scholastic subjects to Zhang G.yu brag pa prior to the year 1146,
3. the Kashmiri Zla ba bzang po (Candrabhadra), who could be that same Candrabhadra, a student of Balacandra, who cured Ras chung pa of his leprosy.

Even more intriguing for possible arguments is the fact that while the *Rgyud bzhi* as a medical scripture has no place even in the outermost horizons of Che rje's consciousness, the words *brgyud bzhi* are in fact used once. But in this passage the word *brgyud* (with and without the 'b' prescript) means 'continuity,' not 'tantra,' and serves as a way of dividing the text of the *Aṣṭāṅgahṛdaya* into four parts: The first continuity is the scene setting. The second, called the *Root Continuity* (*Rtsa ba'i rgyud*) ranges from the first chapter, *On the Desire for Long Life*, through chapter 29 of the *sūtra-sthāna* division. The third is called the *Explanatory Continuity* (*Bshad pa'i rgyud*), and covers four of the six *sthānas* of the text: the Śarīra-sthāna, the Nidāna-sthāna, the Cikitsita-sthāna and the Kalpasiddhi-sthāna; these cover the first out of

[18] Emmerick 1977; 1990; 1991: 67. Yangga spoke of still other textual sources for the *Rgyud bzhi* at the 10th IATS conference.

the Eight Branches of medical practice, the one concerning the body. The fourth, called the *Later Continuity* (*Phyi ma'i brgyud*) is identical to the sixth *sthāna*, the Uttara-sthāna, which contains the main discussion about the remaining seven of the Eight Branches of medical practice: Pediatrics, exorcism (and/or psychiatry), diseases of the upper body, wounds, bites (tusks, fangs), rejuvenation, and virilification (and/or aphrodisia). Notice how three of the four titles for 'continuities' in Che rje's outline are identical to the titles of the *Four Medical Tantras*. Claus Vogel (1963) has charted out the differences in Ayurvedic lists of the Eight Branches, and this demonstrates clearly that the *Four Medical Tantras*' version of the Eight Branches, in both ordering and content, is much closer to that of Vāgbhaṭa than to those of Caraka and Suśruta. This may be a further indication of the importance of the *Aṣṭāṅgahṛdaya* as a source for the *Four Medical Tantras*. It seems possible that a way of outlining the content of the former might even have been a source of the divisions of the latter. In any case, such lines of inquiry will need to receive increasing attention in the near future.

Among the interesting features of Che rje's history, the main one is that it supplies our historical imagination with a time and a place in which the *Rgyud bzhi* was not yet the nearly universal sourcebook of Tibetan medical knowledge that it would slowly but surely become. It is of course an interesting and necessary question to pursue: Just how much, and in what precise ways, was Tibetan medicine blessed with an eclectic spirit, which forged a number of local and international influences into something quite new and thoroughly Tibetan?[19] I want only to suggest that Vāgbhaṭa's *Aṣṭāṅgahṛdayasaṃhitā*, with its Tibetanisation and Buddhicisation within the text of the *Four Medical Tantras*, was something more than just one of a number of such influences. It should hold a very central place in future fuller understandings of the history of Tibetan medicine and its very many texts, some of the more important of them, like that of Che rje, unfortunately not yet published.[20]

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[19] Fenner (1996: 465–66) has a thoughtful and useful discussion of this very question.

[20] We may nourish the hope that one day soon someone will find the means to make it available to the Tibetan-reading public. Ideally and eventually, a critical edition ought to be done, since there are oral testimonies from reliable sources that other copies, besides the one in Rome, exist both inside and outside Tibet.

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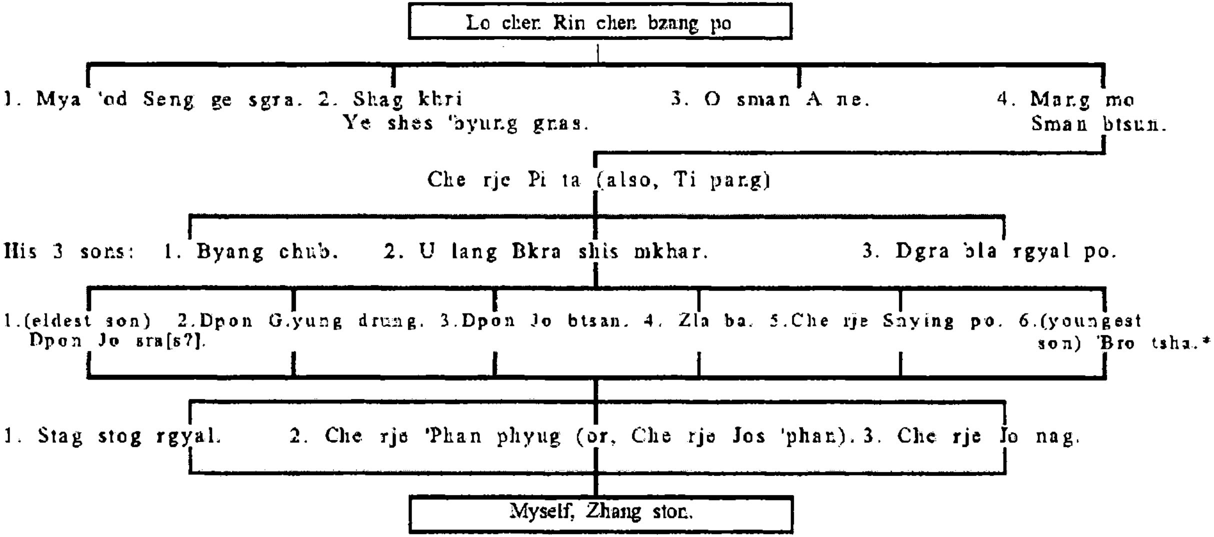
Plate 1: A depiction of Vagbhata in pundit hat, taken from Gtsang stod (1975: I 140). The inscription reads: *dpal ldan pha rgo*[*l*] *la phyag 'tshal lo... dge* [*dga'o*?]. *Pha khol* is the usual spelling.

Plate 2: Vagbhata's commentator Chandranandana depicted as a nude bodhisattva-like figure. Taken from Gtsang stod (1975: I 147). The first line of the inscription reads *zla ba dga'*, the second, *slob dpon* [?] *zla ba la dga' ba.*



* The first three (1-3) were the three elder sons of U lang. Zla ba and Snying po (4-5) were both sons of U lang's youngest son Bro tsha (6).

Figure 1: The Che rje Lineage for the teaching of Vāghata's *Aṣṭāṅgahṛdayasaṃhitā* according to Che rje Zhang ston Zhig po thugs rje khri 'od's medical history entitled *Sman gyi byung tshul khog dbubs rgyal mtshan rtse mo[r?] 'bar ba zhes bya ba'i bstan bcos* [composed in middle spring month of a *shing mo byi* year—CE 1204?], fols 16v-17r.

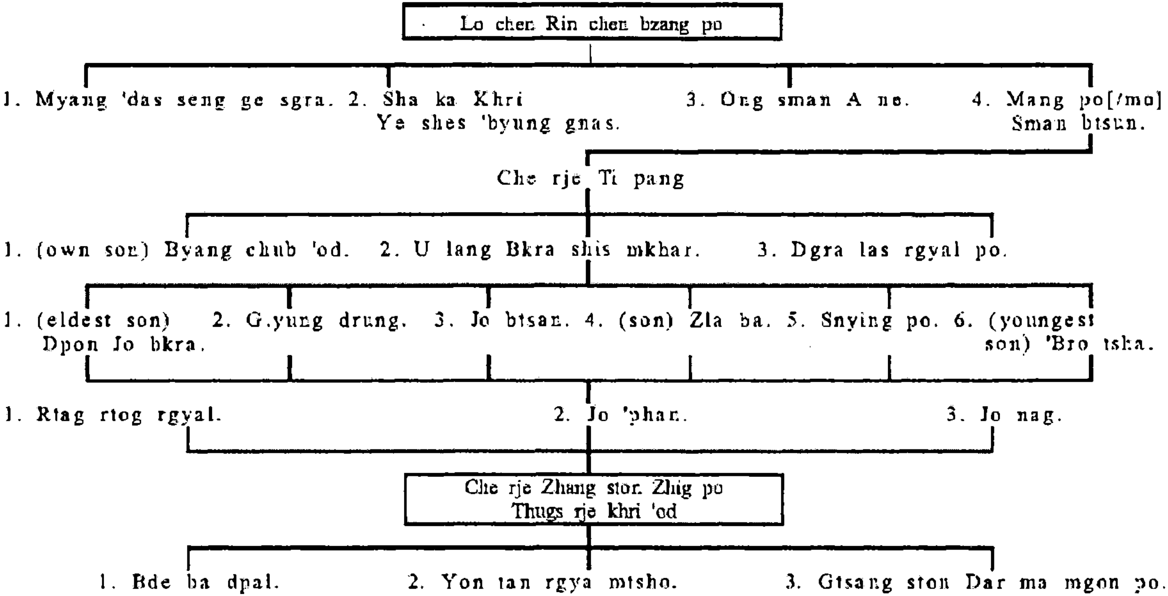


Figure 2: Che rje lineage of Aṣṭāṅgahṛdayasaṃhitā according to Sde srid Sangs rgyas rgya mtsho's *Khog 'bugs*, pp. 177-79 (Old Zhol print, fols. 92v-93r)

TIBETAN AND CHINESE PULSE DIAGNOSTICS: A COMPARISON—WITH SPECIAL REFERENCE TO LOCATIONS FOR PULSE TAKING

ZHEN YAN AND CAI JINGFENG

The palpation of pulse represents one of the most important diagnostic techniques in traditional Asian medical systems. Tibetan sphygmology is very sophisticated and shows strong cultural characteristics. When comparing Tibetan and Han-Chinese sphygmologies, one can detect both similarities and differences. To probe these from a historical and philological perspective is an interesting subject in the study of Tibetology. This chapter aims at clarifying some of the relevant features, especially the controversies over the real nature of the locations for pulse taking, i.e. (Tib.) *(m)tshon-kan-chag* and its relationship with (Chin.) *cun-guan-chi*, and pulse manifestations in Tibetan and Chinese medicine respectively.[1]

A BRIEF HISTORICAL PERSPECTIVE

The knowledge of pulse palpation has a long history in Chinese medicine. Thus, simple descriptions on the location and methods of pulse taking are found in a fragment that was called *Mai fa* (*Method of Mai*) by modern scholars. This collection of manuscripts written before 168 BCE was excavated from the Mawangdui Han tomb near Changsha.[2] Some of the texts indicate that physicians practised pulse taking, for instance:

> For examining *mai* (the pulse), place the left hand five *cun* from the (medial) malleolus and press on it; and place the right hand right above the (medial) malleolus and palpate it.[3]

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[1] We thank Dr Elisabeth Hsu for the encouragement and critical comments which helped to bring this paper into being. Our thanks also go to Dr Mona Schrempf and Olaf Czaja for their thorough reading, corrections and comments on earlier drafts of this chapter, even though there might still remain some controversies.

[2] Ma wang dui han mu bo shu zheng li xiao zu 1985: 9. Cf. Ma Jixing 1992: 292.

[3] Translation based on Harper 1998: 216. 'Malleolus' designates the bony prominence on the inner ankle.

However, the evidence for pulse diagnostics in this document is very fragmentary.

In the 105th chapter of the *Shi ji* (*Records of the Historian*) from about 90 BCE, entitled *Bian que cang gong lie zhuan* (*Memoir of Bian Que and Cang Gong*), it is said: "Due to his examination of *mai* [in particular], Bian Que became famous".[4] Though the *Bian que zhuan* does not report on him having examined *mai* (pulse), Bian Que still is seen as the father of pulse taking in Chinese medical history. Among the 25 medical case histories of *Cang gong zhuan*, the first ten contain extensive records on pulse diagnostics. These ten records contain the first extant text that relates the viscera to the *mai* (pulse) and reports on *qi* in the *mai*, typically it is *qi* coming from one of the viscera.[5]

The *Huang di nei jing* (*Huangdi's Inner Canon*), which was compiled in a long course of time from the Warring States to the Western-Han dynasty (475 BCE- 8 CE), contains an elaborate and diverse knowledge of pulse taking. It compiles and juxtaposes many theories and methods of sphygmology. It testifies to a variety of different lineages in sphymology, however, exactly how many lineages there were, and how their knowledge and practice were transmitted is difficult to ascertain.

The *Nan jing* (*Classic of Questioning*), which dates to around the 2nd century CE, proposes one particular viewpoint, namely that of 'the *cun kou* position' ('inch-outlet' or 'inch-gate', i.e. 'wrist pulses'). This suggests:

> Pulses (*dong mai*) exist in all the twelve channels. Only the position of *cun kou* is adopted as an appropriate position for determining the prognosis of the five viscera and six bowels.[6]

The reason for this is that the *cun kou* is the congregation of all vessels including the 'artery pulse' (*dong mai*) of Hand Taiyin ('lung'-) channel. Having said this, other viewpoints are also put forth in the *Nan jing*, which testify to continuities with the *Huang di nei jing* and the *Mai jing*, discussed below.

In the 3rd century, Wang Shuhe's *Mai jing* (*Pulse Canon*) became the first monograph almost exclusively dedicated to sphygmology (it con-

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4 Our translation, see Sima Qian 1959: 2785.

5 For a study of pulse diagnostics in the *Cang gong zhuan*, see Hsu 2001a and Hsu 2001b.

6 Our translation, see Ding Jin 1959: 1.

tains sections on the inspection of the complexion [*se*] as well), in which not only the importance of the *cun kou* position is ascertained, but also that of *cun* (inch), *guan* (barrier) and *chi* (foot) that is thus finalised and universally recognised in Chinese medicine throughout history (cf. below pp. 336, 338). These are discussed in the *Huang di nei jing* and the *Nan jing*, including their relations with the internal viscera. In the first chapter of the *Mai jing*, twenty-four different pulse qualities are outlined, and for each a different adjective is allocated.[7]

In Tibetan medicine, the *Sman dpyad zla ba'i rgyal po* (*The Investigation of the Lunar King*)[8] is the earliest extant Tibetan medical classic (author unknown) written in the 8th century, which already mentions the theory of the five viscera, and relates them to the (*m*)*tshon*, *kan* and *chag* in pulse-taking. The text combines the three-humor theory of Āyurveda, the *rlung*, *mkhris pa* and *bad kan*, with the visceral-sphygmology theory of Chinese medicine. At the end of the 8th century, the *Rgyud bzhi* (*The Four Medical Tantras*),[9] which became the most important and famous medical classic in Tibetan medicine, is said to have been compiled by G.yu thog yon tan mgon po the Elder. However, this date remains to be proven historically. It not only contains instructions for pulse taking with locations, pulse manifestations and their relation to the internal viscera, as well as to the four seasons, but also all pulse manifestations, normal and abnormal, are dealt with. In this way, sphygmology in Tibetan medicine became integrated and systematised into textual medical theory.

Through the comparison of sphygmology between Tibetan and Chinese medicine, it will be shown that a large part of Tibetan sphygmology theory is basically similar to the corresponding concepts, terms and usage in Chinese medicine. However, the similarities between the two systems is by no means indicating that the sphygmology of Tibetan medicine totally follows that of Chinese medicine, and certainly not stereotypically. It has its own uniqueness due to various modifications based on its ethno-cultural background.

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7 Wang Shuhe, reprinted 1984: 1.1: 1–3.

8 Anonymous 1985.

9 *Rgyud bzhi* (*The Four Medical Tantras*) is claimed to have been written at the end of the 8th century. However, its editions used today are considered to have been compiled in the 12th century by G.yu thog yon tan mgon po the Younger.

LOCATION FOR PULSE TAKING AND ITS VISCERAL CORRESPONDENCE

Evolution of location for pulse taking

For the locations for pulse taking, there is basically no difference in Tibetan and Han-Chinese medicine. The radial artery proximate to the wrist is the regular site for palpating the pulse in both systems.

The *Sman dpyad zla ba'i rgyal po* mentions the location of pulse feeling as follows:

> (When dealing with the position of pulse taking), examined with the three *tshon* (*sic*), *kan* and *chag*. Take the right hand side pulse for the female (patient) first, and the left hand side one for the male (patient). Having measured (a) finger's length from the long crease at the wrist, one (should) press evenly (on this location), thus there are continuous pulse, enemy pulse and pulse of changing solid and hollow viscera.[10]

In this paragraph, the exact location for pulse taking is still not very clear. We only know that it is situated at the long crease related to the wrist. However, in the most important Tibetan medial classic, the *Rgyud bzhi*, which was most likely compiled later than the aforementioned classic, the problem of location of pulse taking is rendered clearer:

> Location for examination (of pulse), uniformly put the three, *tshon* (*sic*) *kan chag* one after another, a *mtshon*'s length at the first crease of the wrist below the side of the bone protuberance.[11]

This paragraph clarifies three important points for pulse-taking location. First of all, the place for examining the pulse is located at the wrist part with the first crease as its mark. Secondly, the bone protuberance, or the styloid process of the radius bone, is a prominent demarcation. Last of all, the description clearly shows that the 'side' here refers to the medial (aspect) of the styloid process, and a *mtshon*'s length from the crease is the exact site for taking the pulse, because there is no pulse at

[10] *Sor mo gsum ni tshon(sic) dang kan, chag dang gsum gyis brtag par bya, bud med sna la g.yas nas blta, skyes pa yi ni g.yon nas blta, mkhrig ma'i gnyer ma ring po nas, mtheb tshon gcal bar mnyam par mnan, de la rgyun rtsa dgra rtsa dang, don snod 'gyur ba'i rtsa dag go* (Anonymous 1985: 56).

[11] *Blta gnas mkhrig ma'i gnyer ma dang po nas, mtshon gang mar bcal rus pa 'bur po'i ldebs, tshon kan chag gsum ma 'drus snyoms par bzhag* (G.yu thog yon tan mgon po 1982: 559).

all to feel at the lateral side of this styloid process. Thus, the radial artery is, without doubt, the exact vessel for pulse taking in Tibetan medicine.

Besides the radial artery, it is also mentioned that the artery at the dorsum of the foot (*rteria pedis dorsalis*) can also be palpated, but only in a dying man:

> The dying pulse (should be) examined at the back of the foot, because the (elements) are assembled at the extremities (*mtha' nas sdud phyir 'chi rtsa bol la brtag*).[12]

In addition, almost all important ancient medical classics, including Zur mkhar blo gros rgyal po's *Mes po'i zhal lung* (*Ancestors' Instruction*, 16th century), Sde srid Sangs rgyas rgya mtsho's *Baidurya sngon po* (*Blue Lapis Lazuli*, written in 1689), and Blo bzang chos 'phel's *Gso rig sman bcos phyogs bsgrigs gces bsdus snying nor* (*Selected Collections of Tibetan Medicine*, compiled in the first half of 19th century), give a similar or even identical description of this site for pulse taking.

However, these are not the only sites for feeling the pulse. Since ancient Tibetan medicine affirms that there are pulsated arteries distributed all over the body, it is maintained that pulses can be palpated elsewhere. In the series of Tibetan medical paintings commissioned by the regent Sangs rgyas rgya mtsho, Tibetan doctors are palpating pulses at specific locations for special purposes, for example:

> For diagnosing the diseases of the upper part of the body, feel the *gnyid log* pulse ('sleepy pulse') (at the neck).
> For diagnosing the diseases of the lower part of the body, feel the *mig dmar* pulse (at the thigh).
> For diagnosing the diseases of the middle part of the body, feel the *rngul 'dur* pulse (at the axilla).
> For estimating one's life span, feel the pulsation of the heart (over the chest).[13]

Based on these descriptions, it is very clear that the radial artery is not the only location for pulse taking in Tibetan medicine. There are many locations for feeling the pulse in diagnostic practice. Similarly, in

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12 *Ibid.*

13 Our translation of *Blta ba phyi'i stod nad rtogs phyir gnyid log la, phyi'i smad nad rtogs phyir mig dmar la blta ba, bar nad rtogs phyir rngul 'dur blta ba, tshe tshad snying gar blta ba* (Byams pa 'phrin las, Cai Jingfeng 1994: 354–355/359).

ancient Chinese medicine, *bian shen zhen* (whole-body pulse taking) was once practised in ancient time. For example, the *Plain Questions of Inner Canon* includes the method of 'three locations for nine pulse-taking' located at *ren ying* (upper part) and *fu yang* (lower part) of the head-neck, hands and feet.[14] However, around the beginning of the Christian era, the radial artery gradually became an exclusive site for clinical pulse taking. This location is called the *cun-kou.*

The problem of (m)tshon-kan-chag and cun-guan-chi

In terms of the locations for taking the pulse in Tibetan medicine, there exists a long debate. The point of contention is focused on the real nature of the Tibetan term *(m)tshon-kan-chag* and its relations with *cun-guan-chi* in Chinese medicine. Some scholars, especially those in China hold that these terms are the direct extension or the transliteration of the Han-Chinese term *cun* (inch)-*guan* (barrier)-*chi* (foot). For instance, in the Chinese versions of the aforementioned ancient Tibetan texts, including the *Sman dpyad zla ba'i rgyal po*,[15] *Rgyud bzhi*,[16] *Gso rig sman bcos phyogs bsgrigs gces bsdus snying nor*[17] and many others, the Tibetan term *(m)tshon–kan–chag* is directly rendered as *cun–guan–chi.* However, some Chinese scholars object to such kind of translation and maintain that this Tibetan term is an archaic form of Tibetan language, referring to the index, middle and ring (fourth) fingers respectively.[18] Fernand Meyer in his article "Théorie et pratique de l'examen des pouls dans un chapitre du *Rgyud bzhi*" also translates the part on sphygmology from the *Rtsa rgyud* (volume one of the *Rgyud bzhi*) into French (1990: 209-56), giving a contextual explanation and interpretation to the terms, outlining the following: *tshon-kan-chag* refer to the index, middle and ring fingers respectively. He especially discusses the history of *tshon* based on Chinese medical history. He

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[14] See Anonymous 1983: 6.2: 129.

[15] Translated by Ma Shilin *et al.* 1993.

[16] Translated by Li Yongnian 1983; another version translated by Ma Shilin *et al.* 1987; and still another translated by Li Duomei 2000.

[17] Translated by Li Duomei 1982.

[18] See for example Zhong Gejia's "Comparison between Chinese and Tibetan sphygmology" (1996: 87–89) and Li Xianjia's "Querying the idea that the *mtshon, kan* and *chag* in Tibetan medicine derived from *cun, guan* and *chi* of Han-Chinese medicine" (1998: 48–49).

concludes that *tshon* is a Tibetan loan word which refers to a Chinese measuring unit called *cun*. On the other hand, while referring to the *Rgyud bzhi*, he maintains elsewhere that the notion of *tshon*, *phun* and *chag* is a specific Tibetan tradition with its own measurements, yet that *tshon*, *phun* and *chag* are loan words from the Chinese measurement units *cun*, *fen* and *chi* (Meyer 1992: 9).

This issue remains a controversy among scholars, both inside and outside China. In our opinion, though the real nature and conclusion of this problem is still open to discussion, it is worthy of careful and circumstantial clarification.

What are the relations between *(m)tshon-kan-chag* and *cun-guan-chi*? Is there a respective correspondence between them, or are they totally different things? Investigations are needed to clarify these issues.

To the best of our knowledge, in Tibetan medicine, the term *tshon-kan-chag* applied in pulse taking is first seen in *Sman dpyad zla ba'i rgyal po*.[19] Most scholars of Tibetan medicine claim that the *Sman dpyad zla ba'i rgyal po* was most likely derived from Chinese sources. Already Sde srid sangs rgyas rgya mtsho in his *Baidurya sngon po* pointed out that the Tibetan term refers to the "'three famous Chinese terms" (Tib. *rgya nag gi brdar grags pa gsum*).[20] Even though the actual origin of the *Sman dpyad zla ba'i rgyal po* is still unclear, it appears that this sphygmological term is related to a Chinese equivalent—at least neither ancient Indian, Persian nor Greek medical systems did apply a similar term.

However, Sangs rgyas rgya mtsho also mentioned in the same paragraph that the doctor's "index finger at *tshon*, middle finger at *kan*, and ring finger at *chag*" (Tib. *mdzub mo la tshon, gung mo la kan, srin lag la chag*). This also arouses some suspicion as to exactly what the relation is between these two sets of terms. According to Fernand Meyer's translation, this means: "...the doctor's index, middle, fourth fingers called (respectively) *tshon, kan* and *chag*, [which are] Chinese denominations...".[21] However, this is not a Chinese original, because none can

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[19] Though indeed the word *tshon* appears several times in the Tibetan scrolls on moxibustion excavated in Dunhuang (P.T. 127, P.T. 1044), which might have been written earlier than the *Sman dpyad zla ba'i rgyal po* itself, it seems that here *tshon* refers to measurements to locate body points, and has nothing to do with actual pulse taking.

[20] See Sde srid Sangs rgyas rgya mtsho 1982: 1175.

find similar sentences from any Chinese medical texts, either earlier or even later than *Sman dpyad zla ba'i rgyal po.*

Historically, in our understanding, the word *tshon* as now most popularly accepted, means a unit of length measurement (spelt *cun* in Chinese Pinyin system).

It is exactly this unit *tshon* that was named as the location for Chinese sphygmology, i.e. where the doctor's finger is applied for feeling the pulse. In fact, as early as the *Huang di nei jing*, finalised around 2nd century BCE to 1st century CE, and *Nan jing* finalised around the 2nd century CE, the term *cun kou* ('the inch outlet' or 'inch gate') was applied, and defined as a 'gate' where the pulse or *qi* is located and circulated. The *Nan jing* further defines it as: "from the *guan* (barrier) to the *yuji*" (the origin of the muscles of the thenar or 'thumb' eminence).[22] This definition is further clarified by the *Mai jing*, written in the 3rd century CE:

> There is one *cun* (inch) from the *yuji* to the high bone (styloid process of radius), this part is the so-called *cun*; from here to the *chize* (a point situated at the lateral end of transverse crease of cubital fossa), (it measures) one *chi* (foot); the part in between them being called *guan* (barrier).[23]

This is a typical explanation for the etymological meaning of *cun-guan-chi.* The locations of the *cun, guan,* and *chi* were thus finalised and popularly recognised in this period. It is also clear that these three parts are closely related to the *cun* and *chi* measurement with the *guan* (as a 'barrier') in between them. This is exactly the origin of the appellation of *cun-guan-chi* in Chinese pulse palpation. Obviously, it has nothing to do with the titles of the fingers in Chinese medicine.

The misunderstanding or deviation of these terms when it was borrowed from Tibetan medicine should be attributed to the *Sman dpyad zla ba'i rgyal po* and the *Rgyud bzhi,* when this Chinese term was rendered into a phonetically similar and Tibetanised *(m)tshon-kan-chag.* It is very likely that it is a similar case in the *Baidurya sngon po.*

The argument arises when some scholars deny the correspondence between the Tibetanised *(m)tshon-kan-chag* and the Chinese term for

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21 Quotation translated from French original (see Meyer 1990: 221, fn. 52).

22 Said to be authored by Bian Que of the Lu State, reprinted in the Qing dynasty: Question 2.

23 Wang Shuhe repr. 1984: 1.3: 7.

the location of pulse taking *cun-guan-chi*. They identify the term directly with the three fingers used for feeling the pulse, claiming that this term is the archaic form of Tibetan language for the three fingers, the index, the middle and the ring fingers.

We are suspicious of this notion. First of all, no one can show us, so far, any ancient literary sources earlier than the *Sman dpyad zla ba'i rgyal po* that include these archaic Tibetan terms for the three fingers. Neither material from the Dunhuang Tibetan scrolls nor from Zhang zhung culture reveal any evidence that might support this conclusion.

The root of the controversy should be traced back to its origin. Right at the beginning of the introduction of the term *tshon-kan-chag* in the *Sman dpyad zla ba'i rgyal po*, this term is already presented in a confusing way. As has been shown earlier, this is the term for the three parts of the radial artery for pulse taking. However, in this Tibetan medical classic, equivocal Tibetan translations do exist, due to the uncertainty surrounding the meaning of this term. There might even have been incorrect interpretations of the term *cun-guan-chi* that mistakenly refer to the three fingers used in pulse taking rather than to the three locations, as in the case of chapter 15 of the *Sman dpyad zla ba'i rgyal po*. This is the major chapter dealing exclusively with the general theory and all the guidelines for the practice of pulse taking. It is interesting to note that in this chapter the text mentions *tshon-kan-chag* only in a few places. More often, it uses the substitutes *sor mo dang po*, *bar ma* and *tha ma* for the index, middle and ring (fourth) fingers respectively. Hence, one might ask why this text uses these different terms as substitutes if there actually existed such special terms for the fingers? What is more, when feeling the pulse with the fingers, *sor mo dang po* and *tha ma* (fingers) are used frequently instead of entirely using the already existing (if it ever really existed) special term *tshon-kan-chag*. The 'first' finger (*sor mo dang po*) and 'last' (*tha ma*) finger generally refer to the thumb and little finger respectively. Strangely and unusually, in this text these terms are used for the index and ring fingers.

Our analysis here is that the confusion of *tshon-kan-chag*, originally a term for pulse locations, with the names for the three fingers, might be due to Tibetan translation difficulties. Since this first important ancient classic appeared, there is evidence to show that many medical texts and later classics reveal a similar confusion. It is to be assumed that these later classics based their descriptions on previous ones. According to Sangs rgyas rgya mtsho's *Gso rig sman gyi khog 'bugs*

(*History of Tibetan Medicine*), G.yu thog the Younger, for instance, when revising and compiling the *Rgyud bzhi*, added the contents of pulse taking to the *Phyi rgyud* of *Rgyud bzhi* by adopting its contents from *Sman dpyad zla ba'i rgyal po*.[24] In the text *Bye ba ring bsrel*, to give another example, the use of the term *(m)tshon-kan-chag* is furthermore avoided altogether, apparently so as to escape these controversies. In the first chapter of the volume on diagnostics (*brtag thabs kyi skor*) of this classic, the author, Zur mkhar mnyam nyid rdo rje, used only *sor mo gsum* (the three fingers), with *mdzub mo*, *gung mo* and *srin lag* for the index, middle and ring (fourth) finger respectively throughout his text. So, how might we reasonably explain why, if there really is an archaic form *(m)tshon-kan-chag* that was used in ancient times to designate the three fingers, these ancient classics avoid the use of these existing words, and why they should have used substitutes and ordinary terms for the fingers? There can be only one reasonable interpretation so far: no archaic form of a Tibetan term *(m)tshon-kan-chag* ever existed.

So far, almost all serious Tibetan dictionaries on old Tibetan language do not include the term *(m)tshon-kan-chag*, showing that this term was not in currency in the ancient Tibetan language, otherwise, it would have been included.

In Chinese medicine, the site where the wrist radial artery is felt is named *cun-kou* (inch gate), which is separated into three portions, the *cun* (inch), *guan* (barrier) and *chi* (foot), separately examined by the doctor's index, middle and ring fingers. Thus, the Chinese also call the pulse examined here the *cun* pulse, *guan* pulse and *chi* pulse respectively. In other words, no pulse in parts of the body other than *cun-kou* can be called *cun-guan-chi* pulses, denoting that it is an exclusive term for radial artery pulse. If we assume—as some scholars do—that the Tibetan term *tshon-kan-chag* really stands for the three fingers, and if this term is no longer exclusively applied to the radial artery pulse (as it is in Chinese medicine) but to other locations at the body as well, should then all the pulses taken at these places also be called *(m)tshon-kan-chag*? For example, when one examines the carotid artery (*gnyid log rtsa*), femoral artery (*mig dmar*), axillary artery (*rngul 'dur*) [see above] or other arteries elsewhere with the same three fingers?

[24] See Sde srid Sangs rgyas rgya mtsho 1982: 275.

Unfortunately, that is not the case! No Tibetan medical sources reveal such an orthodox title for the pulses other than the wrist pulse!

Throughout the whole history revealed in available written Tibetan medical sources, there exists confusion on whether this term refers to a special location for pulse taking at the wrist, or to the three fingers themselves. So far, no conclusion has been reached. If one assumes that the term *(m)tshon-kan-chag* is an available archaic Tibetan term for the three fingers in ancient Tubo dynasty or even earlier as some scholars maintain, then the reason why some famous ancient Tibetan medical scholars avoided the use of this term—including the author of *Sman dpyad zla ba'i rgyal po*, Zur mkhar mnyam nyid rdo rje and Sangs rgyas rgya mtsho—as well as the frequent replacement of these special terms for the three fingers with the popular common names of index finger (*mdzub mo*), middle finger (*gung mo*) and ring (fourth) finger (*srin lag*) in these serious scholarly works might be viewed as somewhat intentional.

RELATIONSHIP OF PULSE LOCATION TO THE INTERNAL VISCERA

In the aforementioned medical classics of Tibetan and Chinese medicine, one can find descriptions on the correspondence among *(m)tshon-kan-chag* and *cun-guan-chi* and the viscera. They can be summarised as follows:

	Left side		Right side	
	Tibetan medicine[25]	Chinese medicine[26]	Tibetain medicine	Chinese medicine
Tshon [mtshon] (cun)	heart (small intestine)	heart (small intestine)	lung (large intestine)	lung (large intestine)
kan (guan)	spleen (stomach)	liver (gallbladder)	liver (gallbladder)	spleen (stomach)
chag (chi)	left kidney (*bsam bse'u*)	kidney (bladder)	right kidney (bladder)	kidney (bladder)

From the above chart, it can be clearly seen that the details of the relations are basically the same in the two medical systems, except that of *kan* (*guan*) in the left and right hand which is just reversed. It is to be

[25] Cf. Gyu thog yon tan mgon po 1982: 559–60.

[26] Cf. Wang Shuhe, reprinted 1984: 1.7: 16.

assumed that Tibetan medicine established the corresponding relationship of this part in accordance with Tibetan anatomical knowledge.

Unfortunately, due to the confusion about the actual meaning of the term *(m)tshon-kan-chag* discussed above, further confusion also has arisen in the Tibetan medical thankas (see Byams pa 'phrin las *et al.* 1994, No. 56; cf. No. 54 in the version by Dorje *et al.* 1992), where one can find captions for the illustrations as follows:

> The heart and intestine pulses are indicated at the thumb (*snying dang rgyu ma'i rtsa mthe bong la blta ba*);
> The right kidney and bladder pulses are indicated at the right little finger (*mkhal ma g.yas dang lgang pa mthe'u chung g.yas la blta ba*);
> The *bsam se* and left kidney pulses are indicated at the left little finger (*bsam se mkhal g.yon mthe'u chung g.yon la blta ba*).[27]

To our knowledge, such correspondences of viscera with fingers have not been documented elsewhere. I therefore suggest that this strange arrangement was initiated by Sangs rgyas rgya mtsho himself due to the confusion of finger numbering in the *Sman dpyad zla ba'i rgyal po.* It is ridiculous and goes against the common practice of pulse-taking, because it is practically impossible for a doctor to take a patient's wrist pulse with the doctor's thumb and little finger as Sde srid Sangs rgyas rgya mtsho's medical thankas depict. However, to probe this problem to its end, Sde srid's strange arrangement of taking pulse with one's thumb and little finger is not totally groundless. In the *Sman dpyad zla ba'i rgyal po* we can find that when this classic avoids the frequent use of *(m)tshon-kan-chag* and replace it by *sor mo dang po* and *tha ma* for the index and ring fingers (see above), these two fingers are confused and misinterpreted as the thumb and little finger for *dang po* and *tha ma* respectively, hence, the strange illustrations in this medical thangka.

Pulse Manifestation

Normal pulse manifestations

Tibetan and Chinese medicine consider that the normal pulse should beat five beats in a breathing cycle. However, in Chinese medicine,

[27] Byams pa 'phrin las and Cai Jingfeng 1994: 359.

there are other descriptions on *ping mai* ('even pulse'), and 'five times in the breathing cycle' is not the only way reflecting the normal pulse. For instance, in the *Mai jing*, it says that two times in an expiration, and "another two beats in an inspiration"[28] can be seen in a normal man, and there are many other variant views on this.

In Tibetan medicine, normal pulse manifestation is also called 'even pulse'.

> Generally, [concerning] the pulse in a vulgar constitution, there are three kinds of pulse, namely, male pulse which is thick and strong, female pulse which is slender and rapid, and bodhisattva-mind pulse which is long, soft, and mild (*tha mal rten gyi rtsa rgyud rnam gsum ni, pho rtsa mo rtsa byang chub sems rtsa gsum, pho yi rtsa ni sbom la rags par 'phar, mo yi rtsa ni phra la myur bar 'phar, byang chub sems rtsa rgyud ring 'jam la mnyen*).[29]

This classification of pulse nature is absent in traditional Chinese medicine.

In addition, the two systems hold that the pulse manifestations have close connection with the five phases (i.e. the *wu xing* of Chinese medicine, not the five elements of Indian medicine). For example, the liver belongs to wood, while the heart belongs to fire; spleen belongs to earth; the lungs belong to metal, and the kidney to water. These five evolutionary phases are mutually promoted, restricted, generated, and subdued.

Interestingly, from a medical and historical viewpoint, in most cases, Tibetan medicine incorporates the three-humour theory of Āyurveda, the *rlung*, *mkhris pa* and bad *kan* in most aspects, and the five 'big' (*Caturmahābhūta*) theory, the earth, water, fire, wind, space of Āyurveda. *Rlung* invading the lung, for instance, is indicated by empty (*stong*) pulse at the right *(m)tshon* position under the first finger.[30] However, only in the field of pulse taking, Tibetan medicine uses the theory of five evolutive phases of Chinese medicine instead, something that is absent in Āyurveda. The close relationship in the domain of sphygmology between Tibetan and Chinese medicine is very obvious here.

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[28] Cf. Wang Shuhe, reprinted 1984: 1.4: 9.

[29] Gyu thog yon tan mgon po 1982: 560.

[30] Cf. Anonymous 1985: 97.

Pathological pulse manifestations

There are 26 kinds of pathological pulse manifestations in Tibetan medicine, that is 'full' (Tib. *drag*; Chin. *hong*), 'void' (Tib. *stong*; Chin. *xu*), 'thin' (Tib. *phra*; Chin. *xi*), 'retard' (Tib. *dal*; Chin. *chi*), 'rapid' (Tib. *myur*; Chin. *shu*), 'solid' (Tib. *mkhrang*; Chin. *shi*), 'weak' (Tib. *zhan*; Chin. *ruo*), 'tense' (Tib. *'khyig*; Chin. *jin*), 'sunken' (Tib. *bying*; Chin. *chen*), 'hollow' (Tib. *zhar*; Chin. *kou*), 'floating' (Tib. *rkyal*; Chin. *fu*), 'slippery' (Tib. *'dril*; Chin. *hua*), 'mild' (Tib. *bul*; Chin. *huan*), 'speedy' (Tib. *grims*; Chin. *cu*), 'short' (Tib. *spun*; Chin. *duan*), 'large' (Tib. *rgyas*; Chin. *da*), 'tremble' (Tib. *'dar*; Chin. *chan*), 'irritated' (Tib. *mgyogs*; Chin. *ji*), 'decline' (Tib. *rgud*; Chin. *shuai*), 'fast' (Tib. *rgyug*; Chin. *ji*), 'thick' (Tib. *sbom*; Chin. *cu*), 'hot' (Tib. *tsha*; Chin. *re*), 'firm' (Tib. *dam*; Chin. *lao*), 'flash' (Tib. *'khyug*; Chin. *shan*), 'loose' (Tib. *rgod*; Chin. *san*), and 'peaceful' (Tib. *lhod*; Chin. *he*). Some of these words are similar to those of Chinese medicine, such as, tense (Tib. *'khyig*; Chin. *jin*), 'sunken' (Tib. *bying*; Chin. *chen*), 'thin' (Tib. *phra*; Chin. *xi*), 'rapid' (Tib. *myur*; Chin. *shu*), large (Tib. *rgyas*; Chin. *da*) etc. While some pathological pulse manifestations are unique ones, such as 'hot' (Tib. *tsha*; Chin. *re*), 'flash' (Tib. *'khyug*; Chin. *shan*) etc. In Tibetan medicine, all these pulses are closely related to the conditions and diseases of the patient. For instance, "the general symptoms of *rlung* disease are: void pulse like a sac made of leather..."[31] "the symptoms of heat *mkhris pa* disease are thirst, tense pulse..."[32] and so on.

Generally, Tibetan medicine describes and analyses its theory on the basis of three-humour theory, *viz. rlung, mkhris pa* and *bad kan*, of Āyurvedic medicine. In this point it differs significantly from Chinese medicine. However, in the part of pulse diagnostics in Tibetan medicine, the theory of the five phases (wood, fire, earth, metal and water) and their mutual generation and mutual overcoming relationship of Chinese medicine is dominant especially in the context of the pulse taking of the 'mutually overcoming pulse'. For example, when the heart pulse dominates at the time of the kidney, it indicates that 'earth' (spleen) can become wealthy, because 'fire' (heart) generates 'earth' (spleen).[33]

[31] See Gyu thog yon tan mgon po 1982: 106.
[32] See Gyu thog yon tan mgon po 1982: 118.

In addition, among the Tibetan diagnostics, inspection, though also part of it, does not occupy a position as important and popular as pulse taking. In the part of pulse feeling, inspection only appears in the description of death pulse (*'chi rtsa*) and is required to be combined with pulse taking.[34] In this point, it differs significantly from Chinese medicine which stresses that in diagnosis, equal attention should be paid to inspection of colors (of skin, tongue etc.) and pulse manifestations at the same time.

Judging from the above analysis and other features of Tibetan pulse-taking, one can see that the Chinese sphygmology exerts profound influence on its counterpart in Tibetan medicine. However, this by no means indicates that Tibetan sphygmology does not yield counter reaction on the Chinese side. Thus, Tibetan doctors typically feel both wrist pulses of patients simultaneously and anthropological fieldwork in Yunnan province proximate to Tibet showed that many Chinese doctors there also take the pulses at both wrists simultaneously (Elisabeth Hsu, personal communication). Local Chinese doctors obviously have adopted a practice of typical Tibetan flavour. This is quite different from the general way of pulse taking in Chinese medicine as a whole, showing that the Chinese doctors there receive the mutual influence of this better pulse feeling approach, a local phenomenon demonstrating bi-directional flows of cultural ideas and practices, because this type of pulse taking is beneficial for comparison of the two radial pulses, which may occasionally offer useful information or messages for diagnosis and treatment.

In summary, the influence of Chinese medicine on Tibetan pulse taking is considerable, as has been demonstrated by the use of some fundamental ideas, approaches, and terms from Chinese medicine. Concerning the pulse taking locations, the pulse qualities, the pulse-organ-time relations, and the use of the five evolutive phases—uncommon in other areas of Tibetan medicine—there is an astonishing accordance between the two medical systems. Nevertheless, Tibetan medicine integrated these influences into its own medical system and clinical practice. The modification of a medical system through the importation, absorption, or assimilation of culturally different medical knowledge is a common phenomenon in transcultural processes of human history.

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33 Anonymous 1985: 72.

34 Gyu thog yon tan mgon po 1982: 565.

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THE MAKING OF THE *BLUE BERYL*—SOME REMARKS ON THE TEXTUAL SOURCES OF THE FAMOUS COMMENTARY OF SANGYE GYATSHO (1653–1705)

OLAF CZAJA

This paper is a first attempt to trace how the Regent Sangye Gyatsho (1653–1705) composed his famous commentary of the *Rgyud bzhi*, the *Blue Beryl* (*Baidurya sngon po*).[1] Some of its textual sources will be introduced and discussed here.[2] I would like to stress that the findings presented here are preliminary in every respect and may need further refinements.[3] Nowadays the *Rgyud bzhi* forms the pivotal point of traditional medical education. Many commentaries were composed on it.

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[1] The term *baidurya* will be rendered here as beryl. For a discussion of this term, see Winder 1987. Bolsokhoyeva (1993: 25) is of the opinion that in all probability the title of *vaidurya* was given by the Regent as in his other treatises such as the *Vaidurya dkar po* etc., because the Regent was educated in the monastery Vaidurya 'gro phan lta na ngo mtshar rig byed gling. This appears to be very unlikely to me. A detailed discussion on the precious stone *vaidurya* is given by the Regent himself in his *Dkar chag* KCh [455/7–456/26].

[2] The study of Taube (1981) and the introduction to the book *Tibetan Medical Paintings* (1992) by Fernand Meyer were most stimulating and aided the realisation of this paper. Their groundbreaking research is acknowledged here. Beside this, I wish to thank Richard Blitstein/Chicago for his untiring efforts in proof-reading the English version of this paper.

[3] Many texts that Sangye Gyatsho used were not at my disposal and some of them are not extant anymore. Most important among them is certainly the medical history of Blo gros rgyal po (*Sman pa rnams kyis mi shes su mi rung ba'i shes bya spyi'i khog dbubs*. Che'eng tu: Si khron mi rigs dpe skrun khang, 2001). A good overview is given by Taube (1981: 73 ff). At the time of his research, however, he was not able to rely on the most important source of the regent, the *Khog 'bugs*. Therefore, the outline presented by him is affected by this lack of information. Moreover, since then the situation regarding published Tibetan medical treatises has dramatically changed. Nevertheless, for my list of the sources of Sangs rgyas rgya mtsho given below I used the one prepared by Taube 1981 as a starting point (*ibid.*: 74ff). This appeared feasible to me due to the limited space of this paper. Furthermore, I would like to emphasise that a thorough survey of the entire *Blue Beryl* will reveal a few more medical texts than those used by the Regent. For example, in the chapter on smallpox (*'brum*) a treatise on the treatment of contagious diseases (*Gnyan rims kyi bcos*) is cited. This work is said to have been composed by one Zur sman Legs bshad 'tshol, VNg [666/20], alias Zur mkhar ba Blo gros rgyal po (1509–1579). His personal name was Legs bshad 'tshol. A work under this title, however, is not found among his works known today.

The *Blue Beryl* was, and still is, regarded as one of the most authoritative among them. However, until now, nothing substantial has been known about how Sangye Gyatsho created this work and no evaluation has been made of its place among the history of the commentaries of the *Rgyud bzhi*. In a rough outline, the present article will introduce the medical discourse of the 17th–18th century period in which the author and his *Blue Beryl* were embedded. It will explore his links, by way of some of his teachers, to the Byang pa and Zur pa medical schools that represent the main traditions in Tibetan medicine at that time. Furthermore, a few short case studies will be introduced to shed some light on his working procedure during his composition of the *Blue Beryl*.

THE FIFTH DALAI LAMA'S SUPPORT OF TIBETAN MEDICINE AND THE MEDICAL DISCOURSE IN THE 17TH CENTURY

The well-known and outstanding career of Sangye Gyatsho, called the 'Regent' for short in this article, was fostered by the Fifth Dalai Lama Blo bzang rgya mtsho (1617–1682) who was also influential in guiding him on his first steps in the field of medicine. Later he imparted upon him two important teachings—the *Compendium of Practical Advice* (*Man ngag snying po bsdus pa*) composed by Shakya dbang phyug (b.15th/16th cent.) and the *Ten Million Relics* (*Bye ba ring bsrel*) by Mnyam nyi rdo rje (1439–1475). In comparision to his other proclivities, however, the Fifth Dalai Lama was not very interested in medicine and his knowledge in this area always remained limited.[4] Nevertheless, he promoted medical sciences in many ways, mostly by initiating new

[4] This is also acknowledged by himself. In his voluminous record of teachings received (*gsan yig*) merely one folio is devoted to his medical education. He admits that he did not study the Indian and Chinese medical treatises such as the *Yan lag brgyad pa* and the *So ma ra dza*. Instead, he focussed on the authorative texts that were revealed as treasures (*rnying ma bka' gter*) like the *Rgyud bzhi* and the *Bdud rtsi bum pa*. SY-NgBBZGTsh vol. 1 [39/5–41/1]. In his autobiography the Dalai Lama says under the entry of the year 1639 that he learned the *Rtsa rgyud* and the *Bshad rgyud*. Their arboreal metaphors of classification (*rde'u 'grems*) were explained to him by Byang ngos nas Gzhan phan dbang po, NgBBZGTsh-NTh I [183/14]. The following year he studied the *Phyi rgyud* and the *Man ngag rgyud*, [194/13–19]. The report of Sangs rgyas rgya mtsho is in agreement with this but in addition he gives two teachings—*the Bye ba ring bsrel* and the *Nyams yig brgya rtsa*, and furthermore he says that he practised the instructions of the *G.yu thog snying tig*, KhB [368/1–7]. The Dalai Lama had intensively studied the *Root, Explanation* and *Subsequent Tantras* of the *Rgyud bzhi*, KhB [381/611]. See also VS [384/8–10], [388/12–14]. Cf. also Ahmad 1999: 260.

editions of medical texts and revising old ones.[5] New translations were made during his reign.[6] Moreover, he let his doctors study several medical treatises.[7]

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[5] Thus, the *Cha lag bco brgyad* together with a colophon was printed in 1671, NgBBZGTsh-NTh II [239/7–16], KhB [368/16], together with an edition of the *Mes po'i zhal lung* KhB [368/16], NgBBZGTsh-NTh III [152/1] and the Dra thang version of the *Rgyud bzhi* KhB [368/10].

[6] KhB [371/2–11]. These included not only medical treatises, see Shastri 2002: 139. Concerning medical works translations were made of (1) the *Tshe'i rig byed mtha' dag gi snying bo bsdus pa* by the Brahmin of Ma ho ra in West India, Senya si go da ra ranytso ra; (2) the *Sman bcas phan bde kyi 'khor lo rigs mi gcig pa bdun cu rtsa gnyis* by one doctor of Pha ha in India, Dā na da ba; (3) the *Tshangs pa rig byed rgya mtsho'i yan lag 'dzin pa g.yo pa can* by the doctor who was of the royal house of Ma dhu ra, Ra gu nā tha; (4) Miscellaneous Practices and Advice that Cause Benefit (*phan byed man ngag lag len thor bu*); (5) the work of Ma no ha (see below). All these translations were prepared by the above mentioned Indians and the Tibetan translator 'Dar ba Ngag dbang phun tshogs lhun grub. Work no. (1) is no.5879 of the *Bstan 'gyur* of the Peking edition. Text no.(3) is preserved in the Peking edition work no.5881. It was rendered by both in 1679 at the Potala at the behest of Dar mo Blo bzang chos grags. Some of these translations were later added to the *Bstan 'gyur*. Shastri (2002: 141) writes that in accordance with the Fifth Dalai Lama's order, Dar lo Ngag dbang phun tshogs compiled a new set of *Bka' 'gyur* and *Bstan 'gyur* and that this catalogue was completed in Fire Hare and Earth Dragon years at Mkhar stod lcang gling. This is not correct. In my understanding, Sangs rgyas rgya mtsho simply writes in his *Dkar chag* that the works newly translated by 'Dar lo Ngag dbang phun tshogs on order of the late Dalai Lama were added to the *Bstan 'gyur*. Together with the Bka' 'gyur this set was prepared between the years *me yos* (1687) and *sa 'brug* (1688), KCh [445/4], [192/5], [833/15]. It was part of the commemoration service by the Regent (cf. also Ahmad 1999: 276). Furthermore, there is also another work translated by 'Dar Lo tsa ba entitled *Be'u bum* of the Indian Go da ra, NgBBZGTsh-NTh III [88/21]. Most like ly this is a medical treatise. It might be related to the *Dngul chu'i be bum* that is given in the colophon of the *Bshad 'grel* of the *Mes po'i zhal lung*. This work was edited by Dar mo ba and printed at the Potala press, see also n.79. In the colophon mention is made of the newly translated works of the three Indian doctors Mahā Pandita Go da ra, Dha na dā sa and Rā gu nā tha. One can justly assume that Sangs rgyas rgya mtsho knew these works. In addition one should note here that 'Dar lo Ngag dbang phun tshogs was his teacher on grammar (*sgra*) and astrology (*skar rtsis*), KhB [375/7].

[7] For example, Dge slong Gzhan phan lhun grub who was from the lineage of Gtsang stod Dar rgyas was known for his expertise in medicine. He had received a wide range of teachings. Therefore, the Dalai Lama let him teach his doctors like Dar mo Sman rams pa or Drung 'tsho Ngag dbang lhag bsam. The course of study included: (1) *Compendium of the Eight Branches* (*Yan lag brgyad pa'i snying po bsdus pa*), (2) *Selected Practical Treatments* (*Zin tig bces btus*), (3) *A Measure of Gold* (*Gser bre*), (4) the large commentary on the *Explanatory Tantra* (*Bshad rgyud*) of Byang ba rigs ldan Rnam rgyal grags bzang, NgBBZGTsh-NTh III [19/12]. Sangs rgyas rgya mtsho gives an additional teaching: (5) the laxative remedies with the main ingredient being quicksilver (*Dngul chu gtso bkru*) in the tradition of Grub thub O rgyan pa, KhB [371/13–19].

Of outstanding merit was the Fifth Dalai Lama's specific support on the treatment of eye diseases. Presumably, this interest derives from the fact that the Dalai Lama suffered from a loss of eyesight in his later years. In one instance, he urged one of his court physicians, Sman rams pa Blo bzang chos grags to study the medical knowlegde of the 'Upper Tradition' (*stod lugs*), known as the Dpon tshang gnas tradition from Grva phyi, and in particular its teachings on the surgical treatment of eye disease (*mig 'byed*). At the same time, Sman rams pa Blo bzang chos grags had to learn the practice of the surgical treatment of eye diseases in the tradition of Mahāsiddha Mi tra dzo ki.[8] Also, the Dalai Lama invited the Indian doctor and eye specialist Ma na ho who was active at G.yor po in Southern Tibet to teach his physician Dar mo Sman rams pa in Lha sa.[9] Moreover, some new medical compositions were written during the rule of the Fifth Dalai Lama.[10]

Unquestionably, one has to take into consideration the medical discourse of the period in order to understand the context in which Sangye

[8] NgBBZGTsh-NTh II [262/9–14], KhB [371/11–13]. In the former source one also finds the information that indeed he practised his newly acquired skills and later treated about fourteen men.

[9] NgBBZGTsh-NTh II [460/8]. Sangye Gyatsho says that one work entitled *Opening the Eyes, Worthwhile to See* (*Mig'byed mthong ba don ldan*) by the physician of Shā dzang, Ma no ha, was translated during the reign of the Fifth Dalai Lama, KhB [371/9]. This treatise is preserved in the Peking edition of *Bstan 'gyur* no.5883. Unfortunately it has no colophon. At the beginning it is stated that this is the practice of Ma na ho, the physician of Rgya gar shā dzang, who came from Ba ri pu ra.

[10] Namely (1) Rnam gling Pan chen Dkon mchog chos grags composed in co-authorship with Dar mo Sman rams pa Blo bzang chos grags the so-called *Untied Diamantine Knot* (*Rdo rje mdud 'grol*), a commentary of the *Subsequent Tantra* (*Phyi rgyud*) starting from the chapter on urine analysis (*chu mdo*) that continues the missing parts of the *Mes po'i zhal lung*, KhB [372/1]. Cf. also Taube 1981: 63. The colophon of the *Mes po'i zhal lung* qualifies this statement. It says that Dar mo Sman rams pa Blo bzang chos grags wrote this very commentary. The Rnam gling Pan chen Dkon mchog chos grags made the proof reading. The work was printed at Dga' ldan phun tshogs gling, MPZhL IV [545/1–5]. It was done in the years 1678–79, MPZhL IV [540/5]. It might be that this date of composition concerns the print of all four parts of the *Mes po'i zhal lung*. (see n.79). It is referred to in the *Blue Beryl*, VNg [1463/17], [1467/21]. Then (2), Dar mo Sman rams pa Blo bzang chos grags, Mer mo pa and La ra ba applied written 'explanatory notes' (*'bri mchan*) and made notes (golden embellishments, *gser rgyan*) in the mode of explaining difficult points (*dka' 'grel*) for treatises that had no commentaries KhB [372/4]. This points toward the third part of the *Mes po'i zhal lung* that comments on the *Man ngag rgyud*. Its title is *Man ngag rgyud kyi dka' 'grel legs bshad gser rgyan*. No date of composition is given in the colophon. Regent Sangye Gyatsho is named as patron for the printed edition, MPZhL III [878/4]. See also VNg [1468/1]. Finally (3), a biography of the elder and younger G.yu thog was compiled from old writings by La ra ba, KhB [372/7].

Gyatsho composed his famous commentary. One can assume that the Regent was fully familiar with the contemporary discussions in medical circles. At that time, the 'Bri gung pa, can be singled out as having a medical school in their own right. As some of his remarks indicate, the Regent will have known their representives and most likely some of their writings.[11] It is known that he also wrote other works with medical contents beside the *Vaidurya sngon po* and the *Lhan thabs.*[12] In the

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[11] The Regent mentions a specific issue in the section on moxibustion and vertebrae that there are some who follow the notes of the 'Bri gung pa, VNg [1362/16]. I believe this refers to 'Bri gung pa Chos kyi grags pa (1595–1659) and his pupils. He was trained and also practised as a doctor. He wrote the *Bdud rtsi bka' mchan* (Bla ma skyabs 1997: 203). According to him he wrote also a treatise named *Dka' gnad dogs sel* in response to Regent Sangye Gyatsho (*ibid.*: 204, cf. also Byams pa phrin las 2000: 367ff). This should be, nevertheless, doubted simply for chronological reasons. Concerning him one can gather first hand information from his autobiographical reminiscences written in 1659 (for his medical education, SPGT [131/1], a most interesting passage when he himself fell ill and was treated by doctors [279/4–]). He also met the Fifth Dalai Lama and according to his testimony these meetings were very cordial. It might be worth mentioning here that Chos kyi grags pa had written a treatise on the treatment of *'bam* in 1628 (see BGSRCD [54–63]). This illness, indicated by swollen legs, is said to be caused by bad blood and by serum that descends into the lower parts of the body. The Dalai Lama suffered from this his whole life. But it should be noted that the Dalai Lama was mostly pleased by the expertise that Chos kyi grags pa showed in the *Gshin rje yang bzlog* rite, SPGT [289/3] etc. Chos kyi grags pa himself lists his own compositions in his autobiographical text. Foremost among them are unquestionably his detailed notes on the *Rgyud bzhi* (*gso dpyad kyi rgyud bzhi kar mchan bu zhib pa* SPGT [298/1]). Most likely they are identical to the *Bdud rtsi'i bka' mchan*, mentioned above. In order to come back on the alledged reply by Chos kyi grags pa to Sangye Gyatsho that is maintained by Bla ma skyabs 1997 we have to have look on the former's student, named Dkon mchog 'gro phan dbang po (b. 1631). His medical writings are preserved in the BGSRCD. His last dated treatise is from 1691, BGSRCD [288/11]. He did actually write an inquiry into the *Rgyud bzhi* that is known under the short title *Rgyud bzhi'i dka' gnad dogs sel*, BGSRCD [121–179]. In this he refers to the *Bka' mchan* of Chos kyi grags pa. According to its colophon he started his work on the 10th of the upper half of *sa ga* month of the 12th cycle when he was 57 years old (1688). This date is only a few days after Sangye Gyatsho had finished his *Blue Beryl*. Therefore I believe the reply to Sangye Gyatsho, listed by Bla ma skyabs (1997), is wrongly attributed to Chos kyi grags pa. A more likely candidate is the pupil of Chos kyi grags pa, Dkon mchog 'gro phan dbang po.

[12] Bla ma skyabs (1997: 146f) gives the reply to Lhun sding Rnam rgyal rdo rje (for this reply see below). According to him the title of it is *Dri lan nam gsal byed drang thig srid sgrub kyi mda'*. The Regent himself simply calls it *Lhun sdings rnam rgyal rdo rje'i rdo ring gyan mchog gi lan,* KCh [828/28]. Furthermore, he composed a reply named *Dogs gnas kyi lan dang bcas pa'i chag shog* to Tshe ring 'dzin pa Ngag dpal, KCh [829/1]. Bla ma skyabs 1997 states that the later was from Smin grol gling. Finally there is a reply to Bod mkhas pa Mi pham dge legs (1618–1685) named *Sman rtsis 'khrul ba'i log rtogs dgag pa*, KCh [829/2].

following paragraph, I will give a short survey on the position of Sangye Gyatsho on the main schools of Tibetan medicine and a short discussion on his teachers.

Sangye Gyatsho and the Zur pa and Byang pa traditions

The famous commentator and author on Tibetan medicine, the Regent Sangye Gyatsho, never became a doctor himself, a fact that is always stressed by him and consequently by Western scholars. I believe this fact to be also a point of strength that enabled him to critically question every aspect of the medical knowledge that he had learnt from his teachers. He did not favour any of the contemporary schools of medical expertise, neither the Byang pa nor the Zur pa tradition which will be discussed below. On the other hand, however, he had no practical experience as a physician. In his work on medical history called *Khog 'bugs* he deeply regrets this. He admits that he never treated a patient and did not study for a long period with a physician. Moreover, he says that he never succeeded in memorising the third part of *Rgyud bzhi* on practical applications, the *Man ngag gi rgyud.*[13] Yet it is known that at the young age of seventeen Sangye Gyatsho had learned the other three parts of the *Rgyud bzhi* by heart. In this respect, invaluable for his work on medicine was his pupil Chags pa chos 'phel,[14] whom Sangye Gyatsho praised for his excellent memory.

In contrast to Sangs rgyas rgya msho, the Fifth Dalai Lama and his medical advisors were inclined toward the Zur pa tradition. As representatives of the Zur pa at that time, one should name here the Dalai Lama's court physicians Byang ngos Nang so dar rgyas and Dar mo Sman rams pa Blo bzang chos grags. The Regent himself, however, remained open-minded and unbiased towards the Byang pa tradition.

In the opinion of Sangye Gyatsho, the Zur pa tradition lacked sufficient knowledge of medical practice. Therefore, he turned to the works and representatives of the Byang pa school. At that time, one of the foremost scholars of the later Byang pa tradition was Lhun sdings pa rnam rgyal rdo rje (b. 16th/17th cent.) who was famous for his erudi-

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[13] KhB [383/7–11], Cf. Byams pa phrin las 2000: 284ff. In his *Vaidurya sngon po,* however, he writes that he was 15 years old when he studied the three minor parts of the *Rgyud bzhi,* VNg [1465/13].

[14] He is depicted on the eleventh thangka of the series of Tibetan medical paintings. Here his name is given as Gzhon nu Chags pa Chos rnam 'phel (Meyer 1992: 38, pl.11). Cf. also Bolsokhoyeva 1993: 23f.

tion.[15] Sangye Gyatsho consulted him on various issues. Most valuable were the instructions he received on the 'identification of plants' (*sman ngo*), the drawings of the so-called 'unfolded tree' (*sdong 'grems*)—i.e. arboreal metaphors by which the main medical tenets are summarised—and on 'topographic lines' (*yul thig*) as well as the 'topographic lines of the channels' (*rtsa thig*).[16] The latter probably concerns the localisation of channels, points for applying moxibustion, bloodletting, and so on. Rnam rgyal rdo rje relied on drawings that were handed down by his father Lhun sdings pa Bdud rtsi 'gyur med (b. 16th cent.) and on some that he made himself.[17] The Regent, however, did not agree with him in every respect.[18]

Lhun sdings rnam rgyal rdo rje was most famous for having put a pamphlet on a pillar in Lhasa, in which he polemically refuted the identification of *materia medica* found in the *Mes po'i zhal lung* by Zur mkhar ba Blo gros rgyal po.[19] However, this treatise is one of the most

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[15] In Sangye Gyatsho's account of his ministry from 14 July 1679 to 7 February 1682, one finds an entry for 1680 regarding Rnam rgyal rdo rje. Together with his pupils he was granted 100 *mkhar ru khal* of grain annually for the remainder of his life (Ahmad 1999: 328). Besides his medical expertise he was also renowned for his knowledge on the *Kālacakra Tantra* and its commentary, VNg [1469/7].

[16] KhB [379/18], VNg [1469/9–1479/]. Cf. Meyer 1992: 6. Later Dar mo Sman rams pa Blo bzang chos grags has written a work on this, the so-called *Bshad rgyud sdong 'grems legs bshad gser kyi thur ma* (Byams pa phrin las 2000: 317/4).

[17] VNg [1469/12]. Cf. Meyer 1992: 6. Bdud rtsi 'gyur med is the author of the *Dgos 'dod kun 'byung*. Sangye Gyatsho made ample use of it. On this see below.

[18] For instance on the issue of *srid rtsa*. Here he was in agreement with Rnam gling Pan chen Dkon mchog chos grags and they refuted the view of Rnam rgyal rdo rje, VNg [1470/1].

[19] KhB [372/13], VNg [1469/1]. One should view this, understanding that Blo gros rgyal po had done something very similiar. He is said to have gone to Dbus after he had written his *Mes po'i zhal lung*. There he fixed a letter with questions on the base, way and result (*gzhi lam 'bras gsum*) of medical issues on a pillar in Lha sa three times. He became widely known for this, but he did not get a reply. Even his own pupils could not follow him. Therefore, he made his own commentary for them to explain it with similes. But the majority of his disciples still did not understand him. Finally an answer came from some who were skilled in medicine like Dol mda' nyang ba khang ba, 'Phyong rgyas rol khong pa, Sde ba Lha sa rdzong ba, Yar klung gces grong Nang so Don yod, Skyem nas Bla rta Tshe dbang, Skid shod Na bo Blo gros brtan pa, and Ko rab gad la ba. He was not persuaded. Instead he put up his own answers, KhB [350/15–351/11]. These questions are preserved and were published in the following edition, *Zur mkhar blo gros rgyal po'i gsung rtsom gces btus*. Kun ming: Yun nan mi rigs dpe skrun khang, 2003. I have had no access to this work.

Regarding this pamphlet one should also pay attention to Mi pham dge legs rnam rgyal (1618–1685) because he wrote a treatise in response of it in Rgyal phu in 1670. (Bod mkhas pa Mi pham dge legs rnam rgyal: *Gso rig gzhi lam 'bras bu'i rnam gzag la dpyad pa'i dri lan legs bshad rin po che'i snang ba gsar ba. Replies to Zur mkhar*

celebrated works of the Zur pa tradition. It can be assumed that this criticism made Rnam rgyal rdo rje quite unpopular. Obviously, Sangye Gyatsho had no interest in such trivial and petty rivalries. Instead he took the best of both traditions and in his own words he 'reunited the medical thinking' that once had branched in two—the Zur pa and Byang pa schools. In his *Blue Beryl* there are some cases where the Regent abstained from preferring one view over another but simply retold the different positions of these schools. Otherwise, he generally favored the Byang pa tradition. For example, when curing 'smallpox' (*'brum*) a compounded 'mineral medicine' (*rdo sbyor*) had to be administered. The opinions of what exactly this medicine was made of differed significantly among the two schools. Even though the Regent quoted both explanations he finally agreed with the one held by the Byang pa school.[20]

Sangye Gyatsho and his Teachers

Regarding this topic the medical thangkas are of particular interest here.[21] As is well known, the Regent also initiated the production of medical thangkas in order to illustrate selected subjects of his commentary. Most of them, namely sixty, were commissioned between 1687 and 1688. This was the period during which he wrote his *Blue Beryl*. On some of these thangkas the transmission of seven teaching texts

blo gros rgyal po's regarding the four Tantra medical texts being a Buddhist literature. Reproduced from a rare manuscript from the library of Dr Tenzin Chodrak. Dharamsala: LTWA 1986). Therefore Blo gros rgyal po had written fourteen versified questions on different topics like astrology, *materia medica*, the status of doctors and so on. Undoubtedly this pamphlet was extremely influential on the medical discourse of the period. Moreover, Blo gros rgyal po is known to have written some more works that discuss some issues with doctors of his time (see Bla ma skyabs 1997: 237ff). Surely Sangye Gyatsho would have been familiar with this.

20 VNg [668/14]. There still remain some complicated issues that touch on the practical side of his *Blue Beryl*. Sangye Gyatsho was much concerned about the identification of medicinal herbs. Therefore, he invited doctors from different regions who assisted him in this task. As is widely known, there are immense regional differences regarding their terminology and proper identification. Reviewing his *Blue Beryl*, however, illustrates that his statements derive from treatises written several centuries earlier. In many cases he included them nearly unchanged in his composition. It can be doubted that medicinal herbs labelled with the same name meant the same in distinctive regions and times. Therefore, in the present situation a translation of the names of medicinal herbs of the *Blue Beryl* has to give qualitative statements derived from the respective original source.

21 For an extensive study, see Dorje *et al.* 1992.

received by Sangye Gyatsho are depicted.[22] They are placed on the upper row of the thangka. They consist of:

(1) *The Hundered Practical Notes* (*Nyams yig rgya rtsa*) of Dkon mchog phan dar (1511–1577)
(2) The *Four Treatises* (*Rgyud bzhi*) of G.yu thog mgon po
(3) *The Innermost Essence of G.yu thog* (*G.yu thog snying thig*) by G.yu thog mgon po
(4) *The Vase of Nectar* (*Bdud rtsi bum pa*) by Padmasambhava
(5) *The Practical Notes on Treatment of Black Smallpox with Mantras* (*'Brum nag sngags bcos nyams yig*) by Shong chen Bstan pa'i rgyal mtshan
(6) *The Ten Million Relics* (*Bye ba ring bsrel*) by Zur mkhar ba Mnyam nyi rdo rje (1439–1475)
(7) *The Compendium of Practical Advice* (*Man ngag snying po bsdus pa*) by Mtsho smad mkhan chen Shaakya dbang phyug (b.15th century)

Among his teachers is one of the main pupils of the Fifth Dalai Lama—Gter bdag gling pa (1646–1717) also named 'Gyur med rdo rje, the well-known founder of the monastery of Smin grol gling. From him Sangye Gyatsho received many explantions on the Zur tradition as mentioned in his *Inventory Chart* (*Dkar chag*) on the Fifth Dalai Lama's memorial stupa. According to the transmission line depicted on the medical thangkas the Regent was introduced to the *Hundred Practical Notes* (*Nyams yig brgya rtsa*) by Gter bdag gling pa. As its title already indicates, this short treatise stresses the methods of treatment. It formed one of the main textual sources for the composition of Sangye Gyatsho's *Blue Beryl* and is still extant. Moreover, it seems that Gter bdag gling pa was also responsible for initiating the Regent into the *G.yu thog snying thig*.[23]

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22 This is quite significant as otherwise no *gsan yig* or *thob yig* of the Regent is known. These transmission lines are also found in his *Dkar chag*, KCh [411/15]. Here they are mentioned in full, and not in abbreviated form as partly indicated on the thangkas themselves, cf. *Rgyud bzhi* [411/15], *G.yu thog snying thig* [412/10], *Ddud rtsi bum pa* [412/17], *'Brum nas sngags bcos nyams yig* [412/24], *Bye ba ring bsrel* [412/27], *Snying po bsdus pa* [413/2], *Nyams yig brgya rtsa* [413/4].

23 In his medical history, however, the Regent reports that he requested the Dalai Lama for the initiation into the *G.yu thog snying thig*, KhB [382/13]. Concerning this teaching, see Taube 1981: 7, and elsewhere.

All these works depicted on the medical thangkas are well known and are frequently referred to in medical treatises except the one on smallpox listed under no. 5. Moreover, the latter is not published and nothing is known about its contents. However, in the following, a short inquiry may provide some general thoughts on the question why this very teaching was included in the *Blue Beryl* and what importance it had.

Practical Notes on Treating Black Smallpox through Mantras

Gter bdag gling pa also taught the Fifth Dalai Lama the *Practical Notes on Treating Black Smallpox through Mantras* (*'Brum nag sngags bcos nyams yig*), a text authored by Shong chen Bstan pa'i rgyal mtshan.[24] Interestingly, this work is not listed by Sangye Gyatsho in the colophons of the *Blue Beryl* nor in the *Supplement* (*Lhan thabs*). Furthermore, reviewing the section on smallpox written by the Regent this treatise is neither cited nor does the content of this section differ significantly from the major sources—for instance, as the aforementioned Nyams yig rgya rtsa text does—but it duly follows the trodden path. In the Regent's *Supplement* a section is specifically devoted to the treatment of smallpox. He also mentions some methods of treatment by uttering mantras, but no reference to the text is given. Placing this teaching on smallpox into a broader and historically situated sociomedical context, however, reveals that an inclusion of this particular work among the transmission lines depicted on the medical thangkas would make perfect sense.

In the 17th century, one of the major health threats was smallpox. The autobiography of the Fifth Dalai Lama allows a precious insight into the daily medical issues that are not reflected in medical treatises. The mention of smallpox is a frequent occurrence. One gets the impression that smallpox was a constant companion of his life. In the 12th month of the year 1636 there was a minor epidemic of smallpox in the Lhasa area. Therefore, the Dalai Lama left town and went to Chos lung bkra shis sgang to spend New Year there. Soon afterwards he took his *dge*

[24] This transmission line is depicted on Pl. 9 of the series of Medical thangkas. The complete line of transmission is: (1) Shong chen Bstan pa'i rgyal mtshan, (2) Sngags 'chang Bsod nams rgyal mtshan, (3) Zur rigs Ngag dbang phun tshogs, (4) Gter bdag gling pa 'Gyur med rdo rje (1646–1714), (5) 5th Dalai Lama (1617–1682). Meyer *et al.* 1992, KCh [412/24].

slong vows.[25] In 1639, a large-scale smallpox epidemic ravaged Central Tibet as documented by historiographic sources.[26] In 1640, it was still not under control.[27] In the year 1643, smallpox broke out again, coming from Gtsang to Dbus.[28] The following year the Dalai Lama was forced to leave for 'Dam, when a high official died suddenly of smallpox at Bkra shis lhun po.[29] Indeed such epidemics were not restricted to Tibet but were a pan-Asian phenomenon. It appears that their epicentre was in Northern China. At the beginning of the 17th century, several smallpox outbreaks are recorded for this area.[30] Chang cites a source that speaks of at least nine smallpox epidemics in Beijing alone in less than twenty years (1644–1661).[31]

Not surprisingly, when Chinese imperial messengers arrived in Lhasa in 1649, to invite the Dalai Lama, their invitation was politely turned down by referring to the threat of smallpox and fever in China.[32] Later, when the Dalai Lama had accepted the invitation and had already set off to China smallpox remained a constant peril on the road.[33]

In the year 1672, however, a long time after he had returned from China, the Fifth Dalai Lama fell ill with smallpox.[34] At that time, the Dalai Lama was fifty-five and Gter bdag gling pa was twenty-six years old. In the beginning, the doctors had problems with diagnosing his disease. Ngag dbang lhag bsam, one of the court physicians, feared that it could be 'contagious fever' (*gnyan tshad*), while Byang ngos dar rgyas thought it would be 'plague' (*rims*). Only when some more days had elapsed and the Dalai Lama showed further symptoms, like pain com-

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[25] NgBBZGTsh-NTh I [173/1].

[26] For example, in the biography of the famous doctor 'Bri gung pa Chos kyi grags pa (1595–1659) epidemics of smallpox are noted as well. When he was in Eastern Tibet at the encampment of the Kar ma pa, a smallpox epidemic broke out that he managed to stop by certain rites (after his ordination in 1612 and before he went to Tsa ri in 1625), BGDR [269/18]. In 1639, a smallpox epidemic had swept all over dBus and gTsang. BGDR [277/10]. One might consult also the biography on 'Phrin las lhun grub (1611–1662), the father of Gter bdag gling pa. Some time after 1635 (but before 1638), due to a smallpox epidemic, he spent six months in solitude at the hermitage of Sgo stod smug po, PhLhG-NTh [113a/2].

[27] NgBBZGTsh-NTh I [200/9].

[28] NgBBZGTsh-NTh I [242/19].

[29] NgBBZGTsh-NTh I [245/10].

[30] Cf. Chang 2002, Serruys 1980.

[31] Chang 2000: 181.

[32] NgBBZGTsh-NTh I [296/10–17]

[33] NgBBZGTsh-NTh I [391/8]

[34] For a detailed account, see NgBBZGTsh-NTh II [254/21].

ing from the depth of his bones and vomiting, they rechecked their former diagnosis. Having examined the writings of Tsha rong drang srong dpal ldan rgyal mtshan, they eventually came to the conclusion that it must be smallpox.[35] Besides the administering of medicine many ceremonies for restoring the Dalai Lama's health (*rim gro*) were performed,and among them were some performed by Gter bdag gling pa.[36] In his biography, the latter says that when the Dalai Lama recovered he was lavishly awarded with many gifts. It was then that he met Zur Ngag dbang phun tshogs. Gter bdag gling pa received various teachings from him, among them also the *Practical Notes on the Treatment of Smallpox Disease through Mantras.*[37] On several later occasions, when the Dalai Lama fell ill again, he was repeatedly able to use his medical skills.[38]

With this context in mind, the inclusion of the treatise that deals with the treatment of black smallpox through mantras in the prestigious series of medical thangkas is easily comprehensible.

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[35] On this doctor, cf. Taube 1981: 70 and Byams pa phrin las 2000: 255ff.

[36] NgBBZGTsh-NTh II [256/7–]. The Gter ston Rin pon che 'Gyur med rdo rje made the *gtor bzlog* of the Red Furious (*drag dmar*) in the tradition of Padma gling pa and the meditation (*sgrub*) of Gshin rje 'joms byed, a new treasure treatise (*gter gsar*), *ibid.* II [256/11]. This was followed by the rites of ransoming death (*'chi blu*) and killing the evil spirit (*gdon 'grol*), *ibid.* [258/5]. The autobiography of 'Gyur med rdo rje (1646–1714) also deals with this event. Here one gets the impression, however, that he was the only doctor who treated him and that it was due to his efforts that the Dalai Lama finally recovered. According to him the rites he used were the cast offerings (*gtor bzlog*) of the Red Furious (*drag dmar*), the killing of evil spirits and demons (*gdon byad 'grol*), a ceremony for removing impurities called 'washing-bathing' (*byab 'khrus*), a life-prolonging rite (*tshe dbang*) and especially the *gtor bzlog* of Gshin rje, TBGP-NTh [118/6]. It seems that these rites were regarded as very effective. When the Regent 'Phrin las rgya mtsho fell ill, they were also among those that were applied by the doctors, NgBBZGTsh-NTh II [84/3].

[37] TBGP-NTh [119/4]. The biography written by Gter bdag gling pa does not give this teaching explicitly but the biography composed by his younger brother, DhSh-NTh [73/5], does. In the later source the teacher is called Ldog chu mig pa Zur ston Ngag dbang phun tshogs. Until now nothing substantial could be found on this figure. It might be that he is mentioned on another occasion in the autobiography of the Fifth Dalai Lama. Here one Zur chu mig pa among others is said to have performed a rite for reverting contagious diseases like smallpox from the Tibetan people, NgBBZGTsh-NTh II [487/10–13]. The voluminous *Thob yig* of Gter bdag gling pa does contain many medical teachings with their respective transmission line. But I was not able to locate this particular treatise on smallpox.

[38] This happened, for example, in 1673 when the Dalai Lama was ill with symptoms of *tshad yams*, TBGP-NTh [123/3]. [127/5]. See also NgBBZGTsh-NTh II [335/10], [385/17]. Once he also treated the Regent when he was ill TBGP-NTh [131/6]. One can observe that he first of all relied on teachings with a tantric background, first among them the *G.yu thog snying thig*. There are some instance when he conferred initiation together with authoratative explanations (*dbang lung*) of this particular teaching to doctors, TBGP-NTh [135/4], [148/5], [217/4], [261/2], [261/4].

The Blue Beryl

The *Blue Beryl* was written at the urgent request of one of the Dalai Lama's court physicians, Dar mo sman rams pa blo bzang chos grags, between the 27th day of the fourth Tibetan month of the year 1687 and seventh day of the fourth month of 1688. It did not possess the meticulous structure of the *Mes po'i zhal lung* nor the purely practical orientation of the compilation *Bye ba ring bsrel.* Instead, the Regent Sangye Gyatsho attempted to keep the best of both compositional principles in order to not lose sight of practical issues and to retain a clear structure. At the same time, he tried to include a large part of the material of earlier medical sources.

Compared to its original source texts, the *Blue Beryl* shows a conspicuous tendency of abstaining from giving treatments based on mantras. Instead, mantras and other magical formulae are administered mainly in the *Supplement* (*Lhan thabs*) regardless of their original source for the treatment of diseases. This in turn does not mean that all treatments as described in the *Supplement* are based on mantras. Yet, it becomes obvious that the Regent included some and excluded other mantras in the *Supplement* text for reasons that remain unknown.

Furthermore, it frequently occurs that Sangye Gyatsho refers the reader to his work on astrology, the so-called *White Beryl* (*Vaidurya dkar po*). Therefore, in my opinion, any thorough judgement on the *Blue Beryl* has to consider both of his works.

One of the many obstacles that the Regent had to face while he compiled the *Blue Beryl* was the considerable variety of opinions. Indeed, every doctor cum scholar held his own practical approach, either expressed in the source texts or by the court physicians. This situation might not be so dissimiliar from that of the present. The commentarial literature the Regent had studied was also complicated in its own right. For instance, the *Bye ba ring bsrel* of Zur mkhar ba Mnyam nyi rdo rje had its shortcomings as the Regent says, because its content (*dkar chag*) comprised three or four different medical systems at once. Therefore, what was handed down by many of his pupils turned into a manifold blend.[39] It was a tremendous task for the Regent to review the previous sources of commentaries as well as to compare the different readings of the *Rgyud bzhi* itself.

In 1662, while Sangs rgya rgya mtsho was nine years old, the Fifth Dalai Lama had ordered Byang ngos dar rgyas in Lhasa to make a new

[39] VNg [1457/16–20].

xylographic edition of the *Rgyud bzhi*.[40] His edition was based on the Gra thang version rediscovered by Blo gros rgyal po. This print of the *Rgyud bzhi* also served Sangye Gyatsho as his main textbook for study.[41] He found many inconsistencies, however, as well as obscure words and even omissions. Probably this did not help in writing his commentary either. In 1694, six years after he had finished the *Blue Beryl*, the Regent published a revised *Gra thang rgyud bzhi*.[42] Among the numerous sources for this revision were several different editions of the *Rgyud bzhi*.[43] The version of the Jo nang pa school known as *Rtag*

40 KhB [381/11–19]. Cf. Meyer 1992: 6.

41 In 1670 he made use of the first proof (*phar phud*) to memorise the three smaller treatises (*rgyud gsum chung ba*). KhB [381/19–382/13].

42 KhB [383/11–15]. He mentions the texts that assisted him in this edition. Many are the same ones he used for the *Vaidurya sngon po*. Moreover, there are some treatises that belong to the *tantra* section as the *Dus kyi 'khor lo*, the *Rdo rje mkha' 'gro* and the *Mkha' 'gro rgya mtsho*. Some of the Sutra, the Vinaya and the Abhidharmakosha section. Naturally, the *Kālacakra Tantra* is of major importance to the medical thinking of Sangye Gyatsho. As it is strictly speaking not a medical treatise, however, for this study it will only be refered to here and not be given a separate entry in the listed sources at the end of this paper. See also VNg [1465/16].

43 KhB [383/7–385/16]. Besides other medical treatises, the Regent based his new edition on another printed edition of the *Rgyud bzhi*: the print of Rdzong dga' prepared under the reign of Mang yul gung thang, Khri Bsod nams lde (1371–1404), the so-called "Print of Sgam po" (*sgam po'i par ma*) by Sgam po Nor brgyan pa, the Bo dong printed edition (*bo dong par ma*) and the so-called "Print of Rtag brtan" (*rtag brtan par ma*) initiated by Rje btsun Kun dga' snying po (b. 1575) and continued by Dpon kun dga' rgyal mtshan. The latter is said to have been corrected by Lhun sding Bdud rtsi 'gyur med (b. 16th cent.). The major sources, however, that were taken as a base for this revision were the *Zur mkhar rnying ma'i rgyud sgam nang ma* and the *Phyag dreg ma*. The latter is the version that was found by Blo gros rgyal po (1509–1579), when he searched the region of Nyang smad, KhB [350/12]. It is said to have had golden explanatory notes (*gser mchan*). I suppose that Sangye Gyatsho had used most of these prints if not all of them for his *Blue Beryl*. A superficial investigation gives some evidence for this (*G.yu thog pa'i phyag dreg ma* VNg [444/13], [450/9], *G.yu thog pa'i phyag dreg ma'i mchan* [445/8], *zur mkhar pa'i rgyud sgam nang ma dang sbyo ra'i par gnyis kar* [522/12]). The later printed edition is not listed in his *Khog 'bugs*. Moreover, some of these treatises and numerous other ones were utilised for the printed edition of the *Mes po'i zhal lung* MPZhL III [875/1–876/4]. Surely, the Regent would have known them.

Furthermore, regarding the *Sgam po'i par ma* it is said to have been under the responsibility of Sgam po Nor brgyan pa. It was done at the behest of Sman pa Don grub pa who also did the proof reading, KhB [384/17]. In the autobiography of Chos kyi grags pa (1595–1659), it is said that on several occasions he met Sgam po Nor bu rgyan pa, SPGT [201/3]. On one of these occasions he addressed him as Sgam po sprul sku rje nor bu rgyan pa and received numerous teachings from him of which all were listed; see SPGT [209/5–210/5]. Based on this it might be assumed that the individual named by the Regent and mentioned by Chos kyi grags pa are identical. On Sman pa don grub see Bla ma skyabs (1997: 13 ff.), Byam pa phrin las (2000: 345ff). Both state that he was born in *shing yos* of the 11th cycle (1675). I believe this calls for a full investigation, and it seems reasonable to me to assume for the moment that the cycle in question is not correct.

brtan par ma was revised by Bdud rtsi 'gyur med (b. 16th cent.), the father of Rnam rgyal rdo rje who had a considerable influence on the medical expertise of the Regent. It should be noted that the *Rgyud bzhi* on which Sangye Gyatsho had relied is not the same word-for-word text that he had used at that time and which we are using today.

It appears that among the texts the Regent used for compiling the *Blue Beryl* the most important was the *Sources of All Wishes* (*Dgos 'dod kun 'byung*) written by Bdud rtsi 'gyur med. At the same time it seems that he did not follow the Zur pa tradition as much as one might assume—especially if one compares how the different texts are structured—judging by their general preference at the Dalai Lama's court at that time and also by the Regent's own sympathy towards this medical school.

Nosebleed

If one compares the treatment for a nosebleed, for example, it appears that the Regent agrees with the opinions of his scholarly colleagues Bdud rtsi 'gyur med and Dkon mchog phan dar. A nosebleed is classified according to the type of blood that is emitted.[44] Some of the texts also give advice regarding diet and behaviour.[45] Sangye Gyatsho, however, omitted these dietary and lifestyle modifications. To cure the patient, one should apply moxibustion on the space between the eyebrows as indicated by the text of Bdud rtsi 'gyur med. Surprisingly, this is also recommended as a treatment in the treatise of Grags pa rgyal mtshan.[46] Although the latter also suggests bloodletting of the channels at the crown of the head,[47] this treatment is not advised in any other source. In general the work that is attributed to Grags pa rgyal mtshan did not seem to offer much to Sangye Gyatsho, not just in this case but in others as well. To cure a nosebleed the Regent recommends the fluid

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44 I.e. thin and yellow blood comes from the brain, according to VNg [708/15], KPTshB [229/20], MPZhL III [381/3]. Nothing is said on this in the GDKB; thin and yellow blood comes from injured brain channels NyYGTs [109/1]; pale and yellow blood comes from brain GPKDz [373-3-4]. I did not find any references for the treatment of a nosebleed in the *Bye ba ring bsrel* or the *Zla ba'i rgyal po*.

45 Cold water should be poured over the head and the upper part of the body. A cooling diet and behaviour that cools is recommended. One should relax (GDKB [165/6]) and also put on cooling clothes (NyYGTs [109/3]).

46 Space between the eyebrows bound with fire VNg [708/16], GDKB [165/7], five pieces of cinder on the space between the eyebrows GPKDz [373-3-4].

47 GPKDz [373-3-4].

part of horse dung to be poured into the nose. This can be mixed with other ingredients as mentioned by Bdud rtsi 'gyur med and Dkon mchog phan dar.[48] The Regent ignores the view held by Skems pa tshe dbang and assumingly by Blo gros rgyal po, to solely administer a medicinal herb.[49] Between these two differing approaches stands the *Cha lag bco brgyad*.[50] It appears here that Sangye Gyatsho preferred the expertise of the more practically oriented treatises instead of the advice given in the literature of commentaries.

Gag lhog

If one takes a look at a different disease, Sangye Gyatsho's method of choice is no different. The *Blue Beryl* deals, for example, with a disease called *gag lhog*. *Gag* could be rendered as 'blockage' and *lhog* is said to mean 'carbuncle'. Although these are two different diseases, they are traditionally combined under the same concept. If one tries to relate this concept to a biomecial equivalent, *gag pa* denotes diphtheria, while *lhog pa* is a disease of the muscle tissue caused by infection. To put it in other words, it is a contagious disorder that affects throat and uvula and impedes swallowing. It belongs to the contagious diseases called in Tibetan *gnyan rims*. In the following, we will compare the different systems of classification of these diseases.

Let us first explore the classification scheme for *gag pa*.[51] It is specified as 'male', 'female', 'son' or 'fierceful' *gag pa*. The *Vaidurya sngon po* gives this fourfold order probably based on the 16th century works by Bdud rtsi 'gyur med, Dkon mchog phan dar, and Skyem pa

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[48] The juice (*khu ba*) of horse dung (*rta sbangs*) VNg [708/16]; (juice from) compressed horse dung (*rta sbangs*) with horse skin, (wickweed *rta lpags*), saffron (*gur gum*) and bear bile (*dom mkhris*), GDKB [165/8]; compressed horse dung juice (*rta sbangs*) with raw sugar or salt NyYGTs [109/3].

[49] This medicine is made of the root of horse skin (wickweed, *rta lpags*) with yellow flowers, MPZhL III [381/4], KPTshB [230/2].

[50] It characterises the blood as yellow and coming from the brain. Moxibustion is applied on the space between the eyebrows. The juice of the root of tiger skin (*stag lpags*) is poured into the nose, ChLCG [935/9–11]. The *Cha lag bco brgyad* is a compilation of several texts attributed to g.Yu thog Yon tan mgon po. Cf. Taube 1981: 39ff.

[51] I did not find it in the *Bya ba ring bsrel*. The scheme is: *pho, ma, bu* and *gnyan* VNg [677/1], GDKB [144/19], NyYGTs [87/16], ChLCG [421/13], KPTshB II [207/19]; *pho, mo* and *gnyan* MPZhL [], *dmu khrag 'khyim, ldem mgul 'gags and gag nad yam bu* GPKDz [381-1-1 to 2-1]; *nag po and dkar po* ZBGP [111/13], *gag nad yam bu* ZBGP [192/9], *dkar ba, ser ba* and *sngo ba* ZBGP [193/20], MPZhL [352/1] (Conc. the MPZhL see n.79)

tshe dbang. This coincides with the statements given in the *Cha lag bco brgyad*. The work of Dar mo blo bzang chos grags, however, written as the third (missing) part of the *Mes po'i zhal lung* by Blo gros rgyal po only lists a threefold classification, since the 'son' *gag pa* is missing. In comparision with the *Rgyal po'i dkor mdzod* and the *Zla ba'i rgyal po* we can observe that both treat this subject very differently. The diversity of these early sources stands in contrast to the standardised classification found in the other major sources of the *Blue Beryl*.

To classify the *lhog* disease, several other taxonomies are used. One is based on the four elements earth, water, fire and wind (*sa, chu, me,* and *rlung*). The second employs different colours for description, namely white, black and multi-coloured (*dkar po, nag po* and *khra bo*). The third classification is carried out according to the categories (*rigs*) of *rgod, yang rgod, yam bu,* and *yu mo*.[52] Dkon mchog phan dar (1511–1577) alone gives some interesting information on these schemes. He calls the order of the four elements the Indian system. The one with differing colours represents the Chinese system. The remaining is labelled the Tibetan system. All sources agree on this identification except for the treatise that is attributed to Grags pa rgyal mtshan (1147–1216). Here one finds just a classification into black and white.[53] Notably, it states that the scheme of the four elements is not profound.[54] Most likely this comment points to the *Zla ba'i rgyal po*, one of the earliest extant medical texts. That particular text employs the same classification order next to another one of hot and cold. This bricolage might be interpreted as an example of how, from the 11th to 13th century, the classification scheme was not fixed but still open to different notions and systems. In later centuries, however, this puzzle was solved in favour of one overall accepted scheme. In the 16th century, newly edited medical literature had stabilised this subject. Therefore, Sangye Gyatsho was able to utilise the results of a longstanding and formative process in his commentary, the *Blue Beryl*. We could extrapolate that what we could call a 'medical literary orthodoxy' was developed on the basis of Sangye Gyatsho's commentary, especially after his death, and

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52 NyYGTs [87/1–88/2], ChLCG [421/10–12], KPTshB II [207/17–19], MPZhL III [351/5–6] (Concerning the MPZhL see n.79), *sa, chu, me* and *rlung* ZBGP [111/18], [195/11], *tsha* and *grang* ZBGP [111/18].

53 *Dkar po* and *nag po* GPKDz [381-2-1].

54 *'Byung ba bzhi'i brtags thabs yod zer te mi zab* GPKDz [383-4-1].

we could add that it had its roots in times prior to the 17th century and was possibly already formulated before him.

Another example is the case of the special treatment for *lhog pa.* In general, *lhog pa* and *gag pa* share a common base of treatment methods. However, beside this, there are some treatments that are exclusively applied for either one of them. In this particular case, moxibustion is applied to *lhog pa.* This is described in metaphorical terms, that in my opinion ultimately derive from the *Zla ba'i rgyal po.*[55] The treatment through moxibustion is not found in other medical treatises except for the one of Skyem pa tshe dbang that I believe was copied by the Regent.[56]

CONCLUSION

It appears that Sangye Gyatso's *Blue Beryl* should be seen in light of the intense and multivocal medical discourse that took place in the 17th century. His exceptional treatise also received its authoritative status from the remarkable output of the doctors of his time. The political role he played enabled him to draw on a wide range of sources that can be illustrated in his revision of the *Gra nang rgyud bzhi.* A full inquiry is still needed to give a qualitative statement on how he created his *Blue*

[55] The blockage of the lower part of the valley (*lung gi mdo sgo bgag pa*), VNg [682/7], putting a fire seal on the peak of the mountain (*ri bo'i rtse la me rgya gdab pa*) [682/9], applying moxibustion like surrounding with an army (*dmag gis bskor ba ltar bsreg*) [682/11]. One should compare this with the following passage of the *Zla ba'i rgyal po: ri bo rtse (spyi bo) nas bsnyil pa dang / chu bo (don drug gi rtsa) sgo drug bcad pa dang / lung pa'i mdo sgo (yan lag gi rtsa sgo) bsrung ba dang / rgyal po'i (sman) grong khyer 'joms pa dang / grong khyer (mtha' nas) me yis bskor ba dang / mtha' mar khang chung (skrangs pa) bsreg pa dang / rngan pa byin la (sdud sman) bsad pa'o* ZBGP [198/9–12].

[56] KPTshB III [212/8–213/3]. It should be remarked here that the outline of treatment for *gag lhog* in part resembles the hunting of deer. The disease is removed or 'killed' (*bsad*) and the 'corpse' or 'residue' (*ro*) is later removed. The *gnyan rims* to which *gag lhog* belongs is said to be caused by the seven *srin bu* that live within the human body. When they get disturbed by outer circumstances they cause this illness. I think it would be most interesting to establish the origin of this understanding of the human body and diseases. A comparision with known hunting practises does not provide a link for this, cf. Richardson, H.E. 1990. Hunting Accidents in Early Tibet, *The Tibet Journal,* vol.15, no.4, Shakabpa Memorial Issue, part 1, pp.5–27; Uray, G. 1972. Queen Sad mar kar's Songs in the Old Tibetan Chronicle, *Acta Orientalia Hungaricae,* vol.XXV, pp.5–38. Thanks go to Toni Huber who kindly pointed out both these sources to me.

Beryl. This can only be accomplished by an analytical in-depth study that includes all or most of the sources he relied on. Naturally, this has to be based on a history of ideas of Tibetan medical thinking instead of a mechanically applied survey of textual layers.

Despite the fact that the court physicians of the Dalai Lama were inclined to the Zur pa tradition, Sangye Gyatsho did make use of the expertise of representatives and the literature of commentaries that belonged to the Byang pa school. He attempted to smooth over their differences in order to create an intellectually coherent system regarding the understanding of the *Rgyud bzhi*. In later times the *Blue Beryl* became one of the most authoritative commentaries on the *Rgyud bzhi*. Beside the scholarly merits his composition unquestionably possesses this was undoubtedly favoured by the consolidating power of the Dge lugs pa and the political position of the Regent.

APPENDIX

List of Selected Sources for the Blue Beryl

– *Khyad 'phags spyi sman gyi gter mdzod by Mi dbang rnam rgyal grags bzang* (1395–1475) (?) and Mi'i nyi ma mthong ba don ldan (b.15th cent.)[57]

– *Gso rig rgya mtsho'i snying po ngo mtshar spyi sman gyi phreng ba* by Mi'i nyi ma mthong ba don ldan (b.15th cent.) (?)[58]

– *Dgos 'dod kun 'byung* by Lhun sdings Bdud rtsi 'gyur med (b.16th cent.)[59]

– *Bdud rtsi bum pa* of Padmasambhava[60]

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[57] HTh [662/15], The entry found at the *Lhan thabs* suggests that it was a work of both doctors. But it could also be the case that it signifies two distinctive works by the same author. Byams pa phrin las (2000: 195/9) gives *Khyad 'phags spyi sman* as a work of Mi'i nyi ma mthong ba don ldan.

[58] HTh [662/17]. The author of this is probably Mi'i nyi ma mthong ba don ldan (b.15th cent.). Byams pa phrin las (2000: 195/9) has one text called *Ngo mtshar spyi sman*.

[59] HTh [662/17], VNg [1457/21], KhB [384/11]. This treatise was compiled from short practical advice.

[60] HTh [663/2], [663/17], KhB [384/1]. This treatise is said to have been translated during the first time of the propagation of Buddhism. There exist several treatises that might be the one that was used by Sangye Gyatsho. Bla ma skyabs (1997) offers some

– *Sman bcos be bum* treatises by Skyes bu me lha, A ca rya phyag rdum and 'Khor lo rgyal po of Zhang zhung[61]
– *Sha sbyor rtsa ba'i rgyud*[62]
– *Bya 'bum*[63]
– *Pot khra and Pot dmar*[64] of Gong sman Dkon mchog bde legs (?)
– *Bu don ma* of G.yu thog mgon po (1126–1202)[65]
– *Bya log gi* go cha by one Gong sman pa[66]
– the profound precepts (*man ngag zab mo*) of one Gong sman pa

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entries that might be relevant here. For example, one text called *'Chi med bdud rtsi bum pa la rtsa rgyud gzhung lan yag brgyad pa zhes le'u bcu'i bdag nyid can sogs rgyud gsum bzhugs so* was found by Rdor 'bum chos grags (*ibid.*: 116). The *Khog 'bugs* also speaks of other texts that belong to the authoratative treasure literature (*bka' gter gyi rigs*) like the *Ddud rtsi bum pa*. They were used for the revision of the *Gra thang rgyud bzhi* as well. Beside the *Ddud rtsi bum pa* are named (1) *Bdud rtsi bam po bdun pa*, (2) *Bdud rtsi mchog gi gzhung lugs* and (3) *Snang gsal shel bum*, KhB [383/19].

61 HTh [664/3]. The problem has still to be solved as to whether Skyes bu me lha and A ca rya phyag rdum are the same person or not. Here I prefer to take them separate authors as in my opinion the entry of *Lhan thabs* can be rendered in this way. Bla ma skyabs (1997: 23) gives *Snyan brgyud be bum nag po* and *Chung dpyad be bum sngon po* as works of Skyes bu me lha.

One *Be bum* of 'Khor lo rgyal po is mentioned in *Khog 'bugs* of the Regent, KhB [383/18]. Otherwise it is one work only entitled *Sangs rgyas khog 'bugs gser kyi bang mdzod* that is attributed to 'Khor lo rgyal po, Bla ma skyabs (1997: 32). The same is stated by the Regent but in addition he says that he composed one old medical manuscript that agrees with the *Bshad rgyud*. Moreover he says that 'Khor lo rgyal po is also called Zhang zhung Shes rab 'od. He was a disciple of Rin chen bzang po (958–1055), KhB [179/8]. See also VNg [1465/21].

62 HTh [664/4]. Perhaps this is a text called *Sha sbyor dar ya kan* that is attributed to Atisha (b.972/982) (Bla ma skyabs 1997: 98). The relevant passage in the *Khog 'bugs* states that Atisha and Nag tsho Lo tsa ba Tshul khrims rgyal ba (1011–1064) translated this very treatise KhB [179/9].

63 HTh [664/4]. I could not identify this text.

64 HTh [664/4] His possible authorship was already pointed out by Taube (1981: 75). Bla ma skyabs (1997: 42) gives three treatises : *Man ngag po ti dmar po*, *Man ngag po ti nag po* and *Man ngag po ti khra bo*. See also Byam pa phrin las 2000: 233. These are most likely the works written by Gong sman Dkon mchog bde legs.

65 HTh [664/5]. This is listed by Bla ma skyabs (1997: 249) as *Nyams yig bu don ma*.

66 HTh [664/5]. I did not find information regarding this treatise. They are only said to be the profound advice (*man ngag zab mo*) of one Gong sman pa. One work named Ja log is possibly related to this. It was written in a collaborative manner by the so-called three incarnated sons (*Sprul pa'i sras gsum*). These are the Indian doctor Dha rma ra dza, the Chinese doctor Ha shang ma ha and the doctor of Khrom Tsan pa shi la ha. The work in question is entitled *Gso byed 'phrul gyi mdzod rin po che'i sgron me zhes bya ba las de'i ja log* (Bla ma skyabs 1997: 163). There is also a text called *Ja log nor bu dri ma med pa*, KhB [171/17].

– *Lag len pod chung* of Brang ti[67]
– *Nyams yig brgya rtsa or Phan bde brgya rtsa* by Gong sman pa Dkon mchog bde legs [68]
– *Zin tig be'u bum* by Gtsang stod Dar mgon[69]
– *Bye ba ring bsrel* by Mnyam nyi rdo rje (1439–1475)[70]

[67] HTh [664/5], VNg [1457/6], [1465/22]. This is probably the work of Brang ti 'Jam dpal bzang po. It is known under the title of *Sde tshan lnga 'grel lam phyi ma rgyud sbyor tshad lag len pod chung* (Bla ma skyabs 1997: 188). One should remark here that G.yu thog mgon po has written a work called *Lag len pod chung* (Bla ma skyabs 1997: 249).

[68] HTh [662/6], [664/7], VNg [1457/15]. This work represents a compilation of diverse, short practical advice by Dkon mchog bde legs who does belong to the Shigatse school. Nearly all of them have a final statement that this very treatise was given to a particular student who is named. Frequently, the addition of "given to me NN" is found. This makes one believe that this compilation was possibly created after the death of Dkon mchog bde legs. In one case a teaching is preserved that is not of his hand but was composed by Zhag [Zhang] ston zhig po, NyYGTs [98/15]. This work is entitled *Bdud rtsi'i thigs pa*. It might be related to the work listed by Taube 1981 under the name *Lag len dmar khrid rgan mo mdzub chugs kyi chul du 'chad pa bdud rtsi'i thigs pa* (Ibid.: 65, n.243). Not surprisingly references are found that give evidence of the Sa skya rooting of this medical treatise, NyYGTs [34/10], [44/3], [145/10], [148/14], [216/10]. In particular Khyung po rnal 'byor is mentioned as the teacher of Kun dga' snying po, [114/8], [116/10]. Moreover on two occasions the precepts of one 'Brong rtse chos rje are given, [114/8], [116/10]. It might be that this points to Lha sras rgya mtsho, see n.71. But a comparison of the only relevant passage did not offer similarities.

[69] HTh [662/9], [664/7], VNg [1457/15]. Both alternative spellings are found for the title: *Be'u bum* and *Be bum*. Gtsang stod Dar ma mgon po is known to have composed two works: the *Zin tig* and the *Yang tig* (Bla ma skyabs 1997: 216), KhB [179/2]. They are still extant but they were not at my disposal for this study: Dar ma mgon po, Gtsang stod. *Slob ma la phan pa'i zin tig: a collection of instructions on Tibetan medicine and treatment.* Gangtok: Sherab Gyaltsen Lama, 1976, and: Dar ma mgon po, Gtsang stod. *Slob ma'i don du zin thig and Bu la gdams pa yang thig; two works on the essentials of Tibetan medical practice.* Leh: Tsering Paljor, 1975.

[70] HTh [664/8], VNg [1457/17]. This text is a compilation of various short treatises. Zur mkhar ba Blo gros rgyal po (1509–1579) has written a table of contents (*dkar chag*) of it under the title *Bye ba ring bsrel gyi dkar chag mkhas pa'i yid 'phrog* (Bla ma Skyabs 1997: 238, text no.9). This is part of the edition that was at my disposal under the slightly differing title of *Bye ba ring bsrel gyi dkar chag mkhas pa'i yid 'phrog gi lhan thabs dad ldan snyim ma'i me tog*, BBRS [3/1–7/2]. According to him the *Bye ba ring bsrel* used mainly the *'Byung ba lus 'khrugs* that on its turn was the base (*gzhi*) for the *G.yu thog snying thig gi geg sel.* For his *dkar chag* he drew on one of Mnyam nyid rdo rje himself entitled *Mkhas pa'i yid 'phrog*. At his time there existed many compilations called *Bye ba ring bsrel*. Some had a content of main texts and subsequent texts (*ma yig bu yig gi dkar chag*) like that made by Mtsho smad mkhan chen. Some were surely not the proper text but miscellaneous writings (*zin bris*) of

– *Gces bsdus rin chen 'phreng ba* by Gangs khrod Phyag rdor mgon po (b. 16th cent.)[71]
– *Be'u bum* by 'Brong rtse Lha sras rgya mtsho (b. 14th cent.)[72]
– *Gser bre* and the *Dngul bre* of Brang ti Dpal ldan rgyal mtshan (?)[73]

Sgom sman 'Od zer seng ge and Kong po phrag dbon for instance. For his edition Blo gros rgyal po included teachings that were at the end of *Dkar chag* of Mnyam nyid rdo rje. He completed this work in iron femal sheep year (1573). (An additional dating given by him is 198 years after Mnyam nyid rdo rje had passed away. I believe this is a mistake). At the end of the entire composition of Mnyam nyid rdo rje there is a sentence in cursive script. It states that this very *Bye ba ring bsrel* is in agreement with the *Dkar chag* written by myself. There might be a chance that it does belong to Blo gros rgyal po himself.

[71] HTh [662/9], [664/8], VNg [1457/15]. This work and its author have to be seen as belonging to the Gong sman tradition. According to Taube (1981: 71) the *Rgyud bzhi* and the *Bco lag bco brgyad* were transmitted from Dkon mchog phan dar (1511–1577) via Bsam gtan bzang po to Phyag rdor mgon po. In his work he frequently pays hommage to Dkon mchog phan dar (1511–1577), RChPhB [5/12], [23/4] etc. Presumably he was a pupil of him. One work is included that is written by Dkon mchog phan dar. This is the *Tshad pa chang bcos*, [102/12]. One short work is also written by Brang ti Dpal ldan 'tsho byed, [278/7]. Other medical traditions are mentioned as well, such as Zhang ston zhig po [103/1], [238/8], Zur mkhar ba [428/4] and Gtsang stod Dar mgon [435/15]. At one occasion also the tradition of 'Brong rtse is refered to, [252/14]. Besides the edition used here there is still another that I was not able to obtain. (Zur 'tsho po phyag rdor mgon po. *Man ngag gces bsdus rin chen 'phreng ba: a collection of Tibetan ayurvedic medicinal preparations and practices of the Gong-sman tradition.* Leh: T. Paljor Emchi, 1975.)

[72] HTh [662/9], [664/9]. The *Be bum* is a compilation of several distinctive works. Its colophon does not contain historic data. One of Lha sras rgya mtsho's teachers was Dge legs dpal bzang (1385–1438) BB [49/1]. Here also his full name is given Lha'i btsun pa rin chen rgya mtsho'i blo gros dpal bzang po. He was familiar with the teachings transmitted in the Brang ti line, [10/6], [11/13], [126/3]. Moreover he knew the writings of the Sa skya pa in general and Sa skya pandita in particular, [141/6], [216/10], [245/10], [245/17], [284/4]. But more interesting are two passages that may allow us to date approximately this compilation, although admittedly I did not suceed in this until now. His treatise on quicksilver (quite famous in later times) has a colophon. According to this, he was ordered to write it by Chos rje Kun dga' blo gros rgyal mtshan dpal bzang po and on the behest of Mkhan chen Kha tshar ba, Lha btsun Sman bla pa and 'Tsho byed dbang po Dpal ldan rgyal ba, [362/4]. The other relevant passage speaks of one precept of preparing medicine according to the tradition of Gu ru gu ta tsi ti bhi ti. It was written down on the 15th of the 6th month in *lcags pho 'brug* (1400 etc.), when one called Dzo ki tsig ri na tha came to Gnas rnying gzims khang chen mo, [367/10].

There are two other published versions of this *Be'u bum* that were not utilised for this short overview. (Lha btsun Rin chen rgya mtsho'i blo gros. *'Bron rtse be'u bum chen mo.* Lha sa: Bod ljons mi dmans dpe skrun khan, 1987; and 'Brong rtse lha sras rgya mtsho. *'Bron rtse'i be'u bum dkar po: a coll. of esoteric medical prescriptions and magical formulae for the alleviation of various ailments; reproduced from a manuscript preserved in the Library of Tibetan Works and Archives*, Dharamsala/Delhi: Sangpo, 1983).

[73] HTh [664/9], VNg [1457/15] The *Lhan thabs* gives the *Gser bre* and *Dngul bre*

– *Sman dpyad rgyal ba'i dkor mdzod* by Rje btsun Grags pa rgyal mtshan (1147–1216) [74]
– *Snying po bsdus pa* by Mtsho smad mkhan chen Kun dga' rgyal mtshan[75]
– *Zab bcud kun 'dus* by Nam mkha' rgyal mtshan from Dbu ru[76]
– *Yan lag brgyad pa'i snying po bsdus pa* and its autocommentary[77]
– *Zla zer* by Slob dpon Zla ba la dga' ba[78]
– *Zla ba'i rgyal po* by Klu sgrub[79]

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of Sa skya sman grong pa. It might be that there existed several treatises under these titles within the Sa skya medical school. It is known that Brang ti Dpal ldan rgyal mtshan had composed the *Man ngag gser bre ma* and the *Man ngag dngul bre ma* (Bla ma skyabs 1997: 184; cf. also Taube 1981: 76). This published work I could not consult: *Gser bre chen mo: a collection of medical formulae and incantations of the Brang ti lineage*. Leh: T. Paljor Emchi, 1975.

[74] HTh [664/10]. This treatise partly resembles a compilation. Topics already dealt with come up again later. One should cast doubts on its authorship. Most probably it was compiled by the nephew of Grags pa rgyal mtshan, Sa skya pandita Kun dga' rgyal mtshan (1182–1252). There are frequently remarks like in the opinion of Grags pa rgyal mtshan and his younger brother (i.e. Dpal chen 'od po, 1150–1203) GBKDz [384-3-2], [385-2-2], [385-2-6], [386-3-4], [387-3-5], [357-3-5]. This is in line with the description given by Ngor chen Kun dga' bzang po (1382–1444) in his *Dkar chag* on the Collected Works of Grags pa rgyal mtshan. According to him it includes (1) instructions of the *Yan lag brgyad pa* composed by Nagarjuna and transmitted to Rin chen bzang po (954–1055), (2) precepts that came from the Translator of Mal gyo Blo gros rgyal po (11th cent.) and (3) miscelleanous precepts of Kun dga' snying po, Grags pa rgyal mtshan and Dpal chen 'od po, SKKCh. The last part of the *Rgyal po'i dkor mdzod* only on the treatment of head (the *Gso dpyad bdud rtsi'i thigs las mgo dpyad padma dri med*) diseases appears to me as composed by Grags pa rgyal mtshan. Therefore the *Rgyal po'i dkor mdzod* represents the medical knowledge that was handed down within Sa skya school from the 11th to 13th cent.

[75] HTh [664/11], VNg [1466/1]. This work is not longer extant (Taube 1981: 61f). Bla ma skyabs (1997: 19) gives the title *Gdams pa thams cad kyi nang nas ches zab pa man ngag kun gyi snying bo bsdus pa*.

[76] HTh [662/10], VNg [1457/20]. This work I could not identify.

[77] KhB [383/15], KhB [383/16], VNg [1465/18].

[78] KhB [383/16], VNg [1465/18].

[79] VNg [1465/21]. The authorship of this treatise is rather complicated (Taube 1981), see also KhB [152/1].

– *Mes po'i zhal lung* by Zur mkhar ba Blo gros rgyal po (1509–1579)[80]
– commentaries by Skyem pa Tshe dbang[81]

80 VNg [1457/10], [1466/22]. This commentary on the *Rgyud bzhi* was designed to cover all its four parts. But the commentaries of the *Root* and the *Explanatory Treatises* (*Rtsa bshad 'grel*) only were completed together with the first chapter of the commentary of the *Phyi rgyud*. According to the *Khog 'bugs* this took four years and the needs for writing were provided by Sa spyod Dbang rgyal grags pa, KhB [350/13]. A look on the colophons of the printed edition provides further data. Therefore the commentary on the *Rtsa rgyud* was written in 1542. Chos kyi rgyal po Rgyal dbang rdo rje grags pa rgyal mtshan dpal bzang po (whom I have not yet been able to identify) provided all that was necessary for writing it. It was composed at the behest of 'Tsho byed Tshe dbang rgyal po, who was the son of Tshe 'bum rdo rje known for his 'practical skills' (*lag len mthar phyin*) among the main disciples of Mnyam nyid rdo rje (1439–1475). Obviously this is the very Skyem pa Tshe dbang who wrote a famous commentary on the *Rgyud bzhi*. The *Khog 'bugs* speaks also of this teacher-pupil relationship of Mnyam nyid rdo rje, Skyem pa Tshe 'bum rdo rje and Tshe dbang, KhB [347/13-18]. The commentary on the *Bshad rgyud* was composed in 1545 in the vicinity of Pa rnam Lhun grub rtse sponsored by the same patron.

81 VNg [1466/22]. These four commentaries on the *Rgyud bzhi* were separately known as follows: the commentary on the *Rtsa rgyud*: (1) *Snying po snang ba*, *Bshad rgyud*: (2) *Tshig don nyi ma*, *Man rgyud*: (3) *Bde ba'i 'dod 'jo* and *Phyi rgyud*: (4) *Lag len gsal byed*. Not much is known on the life of his author. Byams pa phrin las (2000: 220) says that he lived in the 15th cent. This statement is based on colophons of (1) and (2). According to this it was composed in *sa phag* year of the 8th cycle (1479). A close inquiry, however, reveals more data and questions. Skyem is a locality in Kong po. He is also known as Bla rta lha rje (bla rta lha rje'i rnam bshad bde ba'i 'dod 'jo, MPZhL III [874/5]). As it is found in his colophons he composed his treatises at Bla rta, the northern gate of Tsa ri, a place in Kong po stod. The dates of composition were: (1) from 8/ *sa ga* month/ *sa pho khyi* year / 8th cycle to last day of *snron* month, (2) from 1/ *gro bzhin* month/ *sa pho khyi* year to 10/ *khrums stod* month/ *sa mo phag* year, (3) the upper half of *tha skar* month of *rab byung* year (attached note: *me mo yos* 9th cycle) aged 54 (53), (4) 1/ 9/ *lug* year. Furthermore, his treatises contain also some information on his teachers. Therefore, the medical knowledge was successively handed down from Zur mkhar ba Mnyam nyid rdo rje, Phag dbon Bsod nams bkra shis, Bla rta ba/ Lha rje Mi dar bkris to Skyem pa Tshe dbang, KPTsB II [2/11], [4/15], III [363/12]. There is no space here to go into the sources that were cited by him in his treatises although they are very interesting. It should, however, be noted that among them one finds in a passage of the importance of grammar and medicine a citation of Ngag dbang 'jigs med grags pa, I [3/16]. Undoubtedly this is the famous Rin chen spungs pa scholar who was born in 1482. Based on this observations it might be justified for the moment to assume that the given cycles are incorrect. Then the dates of composition will be (1) 1538, (2) 1539, (3) 1567, (4) 1571 and he was born in 1514. This would neatly fit into the above mentioned pamphlet put up by Blo gros rgyal po, see n.19. Moreover it corresponds to the colophon of the *Mes po'i zhal lung*, see n.79.

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ChLCG
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KPTshB
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PRELIMINARY INVESTIGATIONS INTO NEW ORAL AND TEXTUAL SOURCES ON BYANG LUGS—THE 'NORTHERN SCHOOL' OF TIBETAN MEDICINE

THERESIA HOFER

INTRODUCTION

The aim of this article is to shed light on the history of Byang lugs, the so-called 'Northern School' (or 'Northern Tradition') of Tibetan medicine, which flourished alongside with Zur lugs, or 'Southern School', in the 15th and 16th centuries in Tibet. Amchi and lay people in and around Lhun sdings, a village in Ngam ring County in the western part of the Tibet Autonomous Region, consider their area to be the birthplace of Byang lugs founder Byang pa rnam rgyal grags bzang (1395-1475) and the region where this particular Tibetan medical school flourished during the following generations of his amchi lineage. I will present ethnographic data from my encounter with the amchi and laypeople of today's Ngam ring county, complemented by secondary literature on Byang lugs, which I drew upon after my return from the field.[1] So far, Gerke (1999) skillfully reviewed and summarised most of this literature on Byang lugs and Zur lugs[2] and provided the first and most comprehensive account on Byang lugs in English. She points out that the prevailing literature is indifferent concerning where the origins of the Northern and Southern Tradition and the area of their dissemination should be placed. Evidently, *byang* and *zur* refer to the different geographical regions of their schools' dissemination and/ or the birthplaces of their founders.[3] So far, in Western literature no specific places

[1] Evidence on the history of Byang lugs is found in the works of Byams pa 'phrin las 1991, 2000; Clifford 1989; Dung dkar blo bzang phrin las 2002; Gerke 1999; Gerke and Bolsokhoeva 1999; Meyer 1992, 1995, 1998; Shes rab rdo rje 1994; Rechung 1973; Sangs rgyas rgya mtsho 1970, 1982, 1994 [1702]; Skal bzang 'phrin las 1997; Taube 1981; Unkrig 1953 and Yon tan 1988, 1989.

[2] She also includes Badmaev 1991 and Byams pa 'phrin las and Wang Lei 1988, not mentioned here in this article. However, she did not have access to the works of Skal bzang 'phrin las 1997 and Shes rab rdo rje 1994.

[3] Gerke 1999: 18. The term Zur lugs, for example, is derived from the name of its founder Zur khar mnyam nyi rdo rje (1439-1475), born in a place described as Zur mkhar

where Byang lugs flourished are mentioned, and only Meyer writes that Byang lugs originated on the northern plateau and Zur lugs in the southern valleys (1995: 116). However, from the Tibetan textual sources it is well-known that Byang pa rnam rgyal grags bzang, the founder of Byang lugs, was born in Ngam ring.[4] This fact, I argue, taken together with the local oral tradition of claiming Ngam ring as the place of origin of Byang lugs, can be used as a starting point to think about the location, socio-political context, and dissemination of this regional medical school that we know so little about.

Given the lack of information on Byang lugs outside the Tibetan speaking scholarly circles of Tibetan medicine, I shall give a preliminary overview of the history of the Byang lugs lineage, its oral transmission and the texts its proponents wrote in order to situate Byang lugs in its historical, political, and geographical context. For this purpose I have revised most of the literature published on Byang lugs,[5] including the famous and influential *Gso rig sman gyi khog 'bugs* by Sangs rgyas rgya mtsho (1994 [1702]: 306-329) and three other Tibetan sources.[6] In the following, I will compare these textual accounts with the oral histo-

kyi la thog in Dwags po, situated in eastern Dbus and to the south of the Gtsang po (Taube 1981: 51, 56). Later lineage holders of Zur lugs also carry the epithet Zur, in, for example, the name of one of their main proponents, Zur mkhar blo gros rgyal po (1509-1579).

[4] Cf. Byams pa 'phrin las 1991, 2000; Sangs rgyas rgya mtsho 1994 [1702]; Skal bsang 'phrin las 1997; Yon tan 1988; Dung dkar blo bzang 'phrin las (2002: 1477-1478) and the history of Ngam ring chos sde monastery by Shes rab rdo rje 1994. The latter is mainly based on Sangs rgyas rgya mtsho's *Vaidurya ser po*. Sangs rgyas rgya mtsho writes that Byang bdag rnam rgyal grags bzang was born in "*dpal ngam rings kyi rgyal sde chen po byang phyogs shambala nye par*" (1994[1702]: 307). Skal bzang 'phrin las (1997: 354) and Yon tan (1988: 95) write that he was born in "*byang ngam rings kyi rgyal sde chen por*".

[5] Note that I had no access to Byams pa 'phrin las (1991, 2000), except through quotes by other authors, and that a complete translation, including philological analysis of Sangs rgyas rgya mtsho's *Gso rig sman gyi khog 'bugs* (1994 [1702]: 306-329) remains a scientific desideratum.

[6] They are: first the *Bod kyi gso rig byung 'phel gyi lo rgyus* (*Historical Account on the Origin and Development of Tibetan Medicine*) by Skal bzang 'phrin las in which, under chapter five, section two, he deals with "How *gso ba rig pa* flourished under Phag mo gru pa rule" (1997: 343-382); second Yon tan's *Bod gyi gso ba rig pa'i lo rgyus kyi bang mdzod gyu thog bla ma dran pa'i pho nya*, in which part nine deals with Byang lugs' proponents; and third, the *Ngam ring chos sde'i lo rgyus* (*History of Ngam ring Chos sde Monastery*), edited by Shes rab rdo rje (1994), which mentions Byang pa rnam rgyal grags bzang on several occasions. The latter was given to me by the abbot of Ngam ring monastery.

ry on Byang lugs that I collected during fieldwork in Ngam ring in 2003. I shall also deal with the question of whether Byang lugs continued to be practised after it supposedly became unified with Zur lugs in the late 17th and early 18th century. This was the time when the work of Sangs rgyas rgya mtsho (1653-1705) gained influence and the provision of a centralised and standardised medical education was begun at Chagpori (Lcags po ri) medical college (founded in 1696). It seems, however, that Byang lugs continued not so much as a distinct school of medical theory and practice, but as a local social phenomenon in Ngam ring. In the discussion and the concluding remarks some reverberations of Byang lugs in contemporary Ngam ring will be discussed.

A LOCAL PERSPECTIVE ON BYANG LUGS

Together with my co-researcher Penpa Tsering from the Tibetan Academy of Social Sciences (TASS) I had already spent about three weeks in Ngam ring, pursuing ethnographic field research on the various ways the local amchi are practicing *gso ba rig pa*, the Tibetan 'science of healing'. We were following common anthropological practice: observing, establishing contacts, participating, informally chatting with as many people as possible and, as time passed, we formally and informally interviewed the amchi and doctors of the two local Tibetan medical and biomedical hospitals, and officials of the Health Bureau. It was the first time for me to systematically apply the methods and tools of anthropology, collecting data for my MA thesis.[7]

Thus my interest in *gso ba rig pa* became known to the people of Ngam ring and I noticed that amchi and local lay people repeatedly mentioned the name of a village called Lhun sdings,[8] and the 'Mentrong of Lhun sdings' (Lhun sdings kyi sman grong), which seemed to be a village name or the name of a household that had some special connection with the practice or history of 'medicine' (*sman*). I

[7] Altogether the research lasted seven weeks during August and September 2003 and took place in Ngam ring's county capital and the four bordering districts of Ka ga, Chu 'og, Bstar brgyud and Ya mo. Together with further research and translations of Tibetan texts it resulted in my MA thesis "Tibetan Medicine in Ngamring", submitted to the Department of Social and Cultural Anthropology, University of Vienna.

[8] Also spelled as Lho ldeng, Lhun ldings, Lho sdings.

also heard that someone of this household or village is thought of as being a descendant of the lineage of Byang pa rnam rgyal grags pa bzang po, the famous doctor and scholar of the 15th century and founder of Byang lugs. I decided to visit Lhun sdings and see whether I could find out more about this supposed 'village of medicine'.

Lhun sdings is situated about 60 km to the northeast of the county's administrative seat Ngam ring (see map). To get from Ngam ring to Lhun sdings we made use of the scarce transportation available—a big truck and small tractors—and we walked, like most of the local people did. It took us one day from Ngam ring to Chu 'og (Lhun sdings' nearest township) and then another day to Lhun sdings itself. This area was mainly agricultural, with farmers, cultivating barley on the fields in the river valley. In contrast, the north of Ngam ring is predominantly nomadic. From afar, we could only see Lhun sdings' monastery on top of a hill south of the Rtog zhung river. As we got closer, the village itself, its mud brick houses at the foot of the monastery's hill, came into sight (Plate 1). According to local government statistics of 2003, there are about 300 inhabitants in Lhun sdings. At our arrival, the 'Ong skor harvest festival had come to the last of its eight days. We joined the festivities and later climbed up the steep slope to the monastery to visit a monk, whom we had met earlier in the county capital. He showed us around this Dge lugs pa monastery, and when we sat in the monastery kitchen, I asked him whether he knew anything about the 'Mentrong of Lhun sdings'. He explained that it was the name of the household of one local family, who was strongly connected to the history of Tibetan medicine, and whom he knew. He also knew about Byang pa rnam rgyal grags bzang and that the 'Northern School' had been taught and practised here. Later he pointed out the house of the Sman grong family and encouraged us to visit them.

A 63-year-old man called Tshe ring thob rgyal received us there. We introduced ourselves, were invited for butter tea and chatted with him. He was willing, and actually seemed very pleased to share his family's history with us, which I recorded and then later translated with the help of my co-researcher:

> Earlier, there was a person called Byang pa rnam rgyal grags po. Or, by full name, he was called Byang pa rnam rgyal grags pa bzang po. He was also given the title lama, as he was an extremely distinguished doctor. He was born here 608 years ago. During his lifetime, he helped so many beings in an extraordinary way. That's how it came about that people

> were saying, that even eating the earth of this Sman grong would cure their diseases. So famous and legendary was this place Sman grong before its destruction! It is because of Byang pa rnam rgyal grags pa bzang po that we are called 'Sman grong'.[9] It means, the place where a doctor is born, and that remained our household name.

This talkative old man had grown up in the house, which he and his family perceived as the actual residence of the 15th century doctor and scholar Byang pa rnam rgyal grags bzang or his subsequent lineage. He and other elderly villagers remembered the former location of the house at about 150 meters from the current residence. He continued to explain that in Tibet there had been different schools of medicine:

> First G.yu thog Yon tan mgon po established Tibetan medicine. He established the theory or system (*gzhung lugs*) of *gso ba rig pa.* Then Rnam rgyal grags pa bzang po established Byang lugs. He imposed his own ideas upon the *Rgyud bzhi* and thus developed Byang lugs a bit differently from the *Rgyud bzhi.* He was an author, wrote books and as such established this school. So because of his explanations Byang lugs came into being. Actually, it is like the *Rgyud bzhi* itself. It is about *gso ba rig pa,* about diagnosis, the different kinds of diseases, about composing medicines, etc. He first studied these *gzhung lugs* books and when he understood them completely, then he wrote his own books and commentaries on them.

Among other medical scriptures, these books had been kept in Tshe ring thob rgyal's former residence, where there had been a small *sman khang*:

> I remember that in our old house there was the *sman khang*, this small room devoted to medicine and the medical scriptures, though we ourselves did not practice medicine anymore. That had stopped two generations previously. Nobody taught and practised medicine in our family during my time, but all the different books of medicine were there. Some of them were also kept in the *chos khang* (altar room).

The times he remembers are the late 1940s. He had been living with his family and his paternal grandmother in the former Sman grong's house to the east of the village. He explained that the brother of his father's mother had been the last amchi of his family who had been directly

[9] Sman grong as well as Sman 'khrungs are possibly spellings of their household name. The first one means 'village or hamlet of doctors', referring to the big house of the amchi family before the Cultural Revolution. The second might be the honorific expression for 'a place where a *sman pa* (doctor) is born'. Another famous amchi lineage, the Brang ti, had worked in the Sman grong of Sa skya (see fn. 33).

taught within the lineage of Byang pa rnam rgyal grags bzang. As the usual transmission of amchi knowledge followed patrilineal descent, this meant that not his grandmother, but only her brother had been taught *gso ba rig pa.* Tshe ring thob rgyal mentioned the latter as having been a very gifted amchi who became famous in the area. But when he was about eighteen, jealousy had arisen among various amchi of the area, and once, when he had fallen ill, he was given the wrong medicine by one of his colleagues. As a result of this most probably poisonous medicine, he died. Tshe ring thob rgyal recalled, that after that incidence nobody could continue to teach *gso ba rig pa* and their "amchi lineage was cut" (*am chi rgyud chad ba red*).[10] However, his parents were eager that the family tradition continue, and after Tshe ring thob rgyal had received basic education at home and a nearby monastery, they sent him to Phun tshogs gling to study *gso ba rig pa.*[11] There he studied under a famous amchi called Rje drung 'dzi, who had been invited to the monastery to teach medicine.

Unfortunately, his teacher died in 1958, when Tshe ring thob rgyal was 17 or 18 years old. Asked about what he did after these years of education as an amchi, he answered:

> I myself by then understood a bit of pulse and urine diagnosis. I practised a little bit as an amchi, carrying the *sman khur* (medical kit), for which I had bought medicines that I gave to the patients. There were some good results.
>
> Then the 'Democratic Reforms' started in 1959 and I could not really continue to practise. When the reforms started, everything changed, but the destruction of the medicines and books, etc., did not start immediately. In the beginning, I had to stop practising, as I was accused of being a representative of the exploiters' class and so I gave the medicines away. I gave them to a doctor and lama from Nye mo, who stayed in Lhun

[10] On another occasion he mentioned that, "...until then there was continuous teaching, and after that it stopped".

[11] Note that Phun tshogs gling is mentioned by Gerke and Bolsokhoeva (1999: 32) in the context of an important newly systematised and edited second version of the *Gra thang rgyud bzhi* of Zur mkhar blo gros rgyal po (1509-1579). See also below, the section dealing with Lhun sdings bdud rtsi 'gyur med, and also Czaja, in this volume. Gerke (2001) mentions Phun tshogs gling as the place where a set of xylographs of the twelfth century medical treatise *Chag lag bco brgyad* was published. However, she erroneously identifies Dga' ldan phun tshogs gling with the Tsong kha pa foundation of Dga' ldan, to the east of Lhasa, founded in 1416 (2001: 28). She evidently means the Jo nang pa centre of Phun tshogs gling which in 17th century was renamed as Dga' ldan phun tshogs gling (Ahmad 1999: 269). Chan reports a famous printing press at Phun tshogs gling (1994: 864), which is also known to have been used for publishing a considerable number of important medical texts.

> sdings at the time. He was here to build a new monastery and also practiced as an amchi. [.....]. After a year or so he got political re-educations and later on was executed by the Chinese. He had been a good amchi [...]. Then in this area there was no good amchi anymore, and there was no possibility to study with anybody. That place called Phun tshogs gling had good doctors before, and in Bkra shis lhun po monastery there were some too, but I couldn't go there. Being labelled a representative of the exploiter's class, which was a serious accusation, I then did farm work, and I also went to do business.

At that point, his family still had the collection of medical and religious books at their old residence. There had not only been the *Rgyud bzhi*, but also different other medical books written by the previous generations of the amchi of his lineage. There was an old and big 'bag for medicines' (*sman khur*) and an old 'medicine spoon' (*sman thur*). During the Cultural Revolution, the Red Guards came to their house and destroyed everything with support of the poor and impoverished local people:

> They threw the books in the river and into the fire and destroyed everything. They went into the altar room, where we had our water offerings in silver and copper cups. They took them and the statues and sold them later on. They ripped apart some of the books, and the thankas and threw them in the river. They did all that in front of me! We were all there, and could only look at the destruction, and could not say anything—with our heads bowed down; we saw it, but could not protest. After that everything was gone.

Recalling these sad memories, Tshe ring thob rgyal was joined by his family, who had returned from taking a bath in the river. His youngest grandchild crawled onto his lap, and with her smiles and jokes he cheered up again (Plate 2).

Everybody called the old man '*a zhang la*', politely addressing him as 'maternal uncle', even though he was not a real *a zhang*, as he told us later. Since his wife had died earlier, and they had no children, a related young couple with their children had moved in with him. Only two years previously were they able to afford to reconstruct this house, after enduring many years of real hardship following the Cultural Revolution with the destructions, repressions, struggle sessions, and the like. By the 1980s, they were also able to take up some of the religious practices. Now the new house had again a shrine room holding the family's statues of Buddhas and saints and one exceptional statue, which Tshe ring stobs rgyal had mentioned during one of our interviews: a

statue of Byang pa rnam rgyal grags bzang. It had been in the possession of Tshe ring thob rgyal for 20 years, since Byams pa 'phrin las, the then director of the Lhasa Mentsikhang and highly revered scholar of Tibetan medicine, came to visit Lhun sdings to inquire about the history of Byang lugs and had given the statue to him as a present.

Consequently, it seemed that not only the local people, and the Sman grong in particular, were aware of the importance of this area in the development of *gso ba rig pa*, but other Tibetan scholars as well. Before dealing with their work, I shall briefly mention two other doctors from Ngam ring who confirmed the importance of the area in the context of the origin and dissemination of Byang lugs.

These two doctors belong to a local amchi and *sngags pa* lineage respectively. They were educated within their families and in local monasteries, and combined this education with *gso ba rig pa* studies at Shigatse's Skyid skyid nad ka Medical School.[12] They had worked as amchi for most of the past 40 years of which they had spent the latter half within the governmental health care system. They also had been involved in establishing an independent Tibetan medicine hospital[13] in Ngam ring in the early 1990s. Previously they had practised in a small Tibetan medical unit within the People's Hospital. This new Tibetan hospital makes Ngam ring an exceptional place concerning contemporary *gso ba rig pa* practice in the TAR, as together with Sog County in Naqchu, it is the only place with an independent Tibetan medical hospital at county level. It was established when some officials from the Lhasa Mentsikhang, among them Byams pa 'phrin las, came to the area in the early 1990s. They stressed the area's importance in Tibet's medical history as 'homeland of *Byang pa rnam rgyal grags bzang*', acknowledged the good amchi currently practicing in Ngam ring and thus facilitated the revitalisation of Ngam ring's *gso ba rig pa* practice within a Tibetan hospital and the establishment of a Tibetan medical factory.

I met the two doctors in Shigatse, where we not only talked about the more recent developments of Tibetan medicine in Ngam ring, but also

[12] Before its destruction in 1959, this school was situated within the premises of Bkra shis lhun po monastery. It had been established during the lifetime of the 9th Panchen Lama (1883-1937).

[13] Independent here refers to its structural, financial, practical and conceptual independence from the biomedical People's Hospital. No biomedical treatment was given there at the time of research. The hospital is under the administration of the Lhasa Mentsikhang, and not the local Health Bureau.

about the history of the place. Both said that Byang pa rnam rgyal grags bzang had lived and worked in Ngam ring, and became an outstanding scholar who eventually founded Byang lugs. They always mentioned Byang lugs together with Zur lugs, which had been founded by Zur dkar mnyam nyid rdo rje (1439-1475). They both agreed that Byang lugs came from the north, and Zur lugs from Lhoka, i.e. the southern region of Dbus, but that,

> the foundation of them is the same, the basis is one; just the way of giving it a name is different. If you combine both of them, then it is Tibetan *gso ba rig pa*. To find out the small details and differences you have to go and read a lot of books. [...]

Both explained that Byang pa rnam rgyal grags bzang had many disciples, "apart from the Sman grong in Lhun sdings", and that he wrote critical and clarifying commentaries on the *Rgyud bzhi*. My impression was that these two amchi perceived Byang lugs as something past that did exist a long time ago, without much importance nowadays.

After providing an insight into the oral history on Byang lugs, I will now look at the secondary literature. The following overview on Byang lugs' lineage, its transmission and the lineage holder's lives and works, is based on the four aforementioned Tibetan sources (Sangs rgyas rgya mtsho 1994 [1702], Shes rab rdo rje 1994, Skal bzang 'phrin las 1997, Yon tan 1988). Mainly, however, I refer to Sangs rgyas rgya mtsho's *Gso rig sman gyi khog 'bug*, as it was the main source used by most of the authors in question.[14] This will allow a comparison between the oral and textual evidence.

THE OUTSIDER'S PERSPECTIVE—SECONDARY LITERATURE ON BYANG LUGS

According to secondary literature, Byang lugs (occasionally also called Stod lugs or 'Upper Tradition'), as well as Zur lugs, started in the 7th

[14] Yon tan 1988 in addition to the *Gso rig sman gyi khog 'bugs* collected and studied 77 Tibetan and Western sources on the history of Tibetan medicine while working in Dharamsala for many years (personal communication, March 2004; also see bibliography at the end of the *Bod gyi gso ba rig pa'i lo rgyus kyi bang mdzod gyu thog bla ma dran pa'i pho nya*). Also, in contrast to most Western scholars, Byams pa 'phrin las, the former head of the Lhasa Mentsikhang, most probably had access to a range of sources only available in Tibet (1990, 2000). As mentioned above, he had also explored the oral history of *Byang lugs* when he visited Ngam ring and Lhun sdings.

rab byung of the Tibetan calendar (1387-1447 CE). The origin of these schools is closely related to two outstanding scholars: Byang pa rnam rgyal grags bzang (1395-1475), and Zur mkhar mnyam nyid rdo rje (1439-1475).[15] In this chapter, I deal only with Byang pa rnam rgyal grags bzang and the oral transmission of Byang lugs, which is also illustrated in a lineage tree in Table 1.

Byang pa rnam rgyal grags bzang (1395-1475)

Rnam rgyal grags bzang was born in the wood pig year of the seventh Tibetan 60-year cycle, i.e. 1395 CE, in Ngam ring, the capital of La stod byang in western Gtsang. He was born into the ruling family (*byang bdag*) of La stod byang, which represented one of the 13 *khri skor* in the Yuan-Sa skya period of the 13th and 14th centuries.[16] His family were descendants of Mi nyag se'u rgyal po who in the late 10th century had founded the Mi nyag empire of Hsi hsia, i.e. the Tangut kingdom to the north east of A mdo.[17] His father was Gu'i gung chos

[15] In the literature, as well as in the local tradition of Ngam ring, Byang lugs and Zur lugs are often mentioned together as Byang Zur. Taube (1981: 52) and Gerke (1999: 23) suggest that they seem to have peacefully coexisted with equal status for about 200 years. Skal bzang 'phrin las writes that debates took place and that competition between them had prevailed on certain aspects of medical theory and practice (1997: 346).

[16] La stod byang ('Northern La stod') lies north of Lha stod lho ('Southern La stod'), to which it was at times allied. In approximately 1268 Hor dkar grags 'od zer (also called Ti shi grags pa 'od zer), a descendant of Mi nyag se' u rgyal po, had accompanied Phags pa (the nephew of Sa skya Pandita) to China. There, Hor dkar grags 'od zer had received the myriarchy seal from Se chen rgyal po, the Yuan emperor, legitimising his family to rule the territory of La stod byang as *khri skor*, with Ngam ring as its capital (see Dung dkar blo bzang 'phrin las 2002: 1478, 1479; Petech 1990: 53; Sperling 1992; Tucci 1972: 192). For the 13 *khri skor* see lists in Tucci 1949: 681-82.

[17] Stoddard mentions 982 CE as the founding date of the Mi nyag kingdom, "when Toba Jiqian (the 'Great Ancestor') openly challenged the Chinese court and formed his own administration" (1997: 81). On the history of the Tangut state prior to its destruction by Genghiz Khan in 1227 and its relationship to Tibet see Stein (1951: 223-65, 1966: 281-89; 1972: 34), Stoddard 1997 and Sperling 1987. After the destruction, the Mi nyag rulers turned to Tibet proper, and after receiving the legitimisation of the Yuan emperor in about 1268, established in Ngam ring the ruling house of La stod Byang with the monastery of Ngam ring chos sde as their spiritual centre. Rdo rje 1994 and Everding 2002, referring to the *Vaidurya ser po*, mention 1225 as the foundation date of Ngam ring chos sde, which was organised in ten faculties. Up to now, only little research has been carried out on the history of Ngam ring, and only some historical details on Ngam ring are found in Everding 2000, Shes rab rdo rje 1994 and Wangdu and Diemberger 1996 where they write about the history of the surrounding principalities. Sperling (1992: 271-77) has partly translated the *Sde pa g.ya ru byang pa' i gdung rabs rin po che bstar ba*, by Dpal ldan chos kyi bzang po (date of writing not confirmed), which is a history of the ruling lineage of La stod byang.

grags dpal bzang and the mother 'Bum skyong rgyal mo.[18] They had six children, out of whom three survived childhood, and two, Byang pa rnam rgyal grags bzang and Chos rgyal dkon mchog legs pa'i rgyal mtshan were to become influential in the myriarchy's further development (Sperling 1992: 275, 276).

About Rnam rgyal grags bzang's childhood the *Khog 'bugs* says that he could relate to what he had learnt in earlier lives by drawing on previous mental faculties. At the early age of about four or five he stayed at the palace of Lho phogs bskyed ma, where he learnt reading, writing and grammar without effort. He then returned to Ngamring and at the age of ten, encountered saints and Buddhas of the past in dreams, from whom he also received oral teachings. He then sought out learned teachers of the time and studied in all fields of *sūtra* and *tantra* under the guidance of Bka' lnga ba Dpal 'byor shes rab rin chen pal bzang, Seng ge rgyal mtshan, Paṇḍita Śāriputra,[19] Mkas grub rin chen dpal bzang and Pan chen nags kyi rin chen.[20] His root-teacher (*rtsa ba'i bla ma*) was Bo dong pan chen Phyogs las rnam rgyal (1376-1451),[21] and he mentions Rnam rgyal rdo rje as one of his disciples in his work on medicine, called *Gso rig khog 'bugs drang srong dkyes pa'i dga' ston* (Skal bzang 'phrin las 1997: 344). He requested vows for lay ordination (*dge bsnyen*) from *Bka' bzhi pa Hor dkar Seng ge rgyal mtshan*, who gave him the name Chos rgyal Rnam rgyal grags bzang. His previous name was Rgya rug Dar ma rig 'dzin.

Ming sources report that Byang pa Rnam rgyal grags bzang received the title '*situ*' in 1413, and thus became the 'Byang pa headman grags pa', while his brother Chos rgyal dkon mchog legs pa'i rgyal mtshan

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[18] She was the daughter of Si tu Chos kyi rin chen (d. 1402) (see Wangdu and Diemberger 1996), who was the founder of Shel dkar rdzong, i.e. the new centre of La stod lho, where Shel dkar chos sde was founded in 1385. He himself was married to a daughter of the Byang bdag family. Their son, and Si tu Chos kyi rin po che's successor was Lha btsan skyabs. He was married to the elder sister of Byang pa rnam rgyal grags bzang, and their son and Lha btsan skyabs' successor, was Nam mkha' tshe dbang bkra shis (see Wangdu and Diemberger 1996: 130 *et passim*, and the *Dpal ldan G.yas ru byang pa'i gdung rabs*, fol. 8, as cited in footnote 136 in Wangdu and Diemberger 1996). It draws the attention to the fact that in the 14th and 15th century the Byang bdag family was in mutual matrimonial relationships with the ruling family of La stod lho (cf. Everding 2002).

[19] Paṇḍita Śāriputra is mentioned as the abbot of the Mahābodhi Temple in Bodhgaya (Gyatso 1994: 308; Sperling 1992).

[20] i.e. Vanaratna, see below.

[21] On Phyogs las rnam rgyal's sojourn in La stod Byang, see his *rnam thar* in Diemberger *et al.* 1997: 67-69.

was named the 'commander'.[22] The two brothers maintained various diplomatic relations, for example with the Rgyal rtse rulers. They revered the Sa skya pa as their principal lama, but also honoured the Jo nang pa, Bo dong pa and Byang sems gzho nu rgyal cog as their masters.[23] They also supported and enlarged Ngam ring chos sde monastery and initiated the construction of a huge assembly hall, the crafting of a tall Maitreya statue in 1434, a Kālacakra statue and many other religious objects.[24] Additionally, they provided material support for the construction of a debating college at Ngam ring chos sde, which subsequently became very famous.[25]

At the age of 31, Byang pa Rnam rgyal grags bzang married the princess Nam mkha' dpal 'bum and had children, among them a son called Nam kha tshe dbang rdo rje. Byang pa Rnam rgyal grags bzang was very fond of Sa skya Pandita's (1182-1252) teachings, and also became a renowned scholar of secret *tantra*. He learned from the Indian scholar and highly revered Pan chen nags kyi rin chen,[26] from whom he took the Kālacakra vows, and studied *sūtra* and *tantra* as well as the

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[22] Sperling 1992: 276. Note that their lifetimes partly coincide with the wane of Phag mo gru pa power in Gtsang. In the 1430s the Phag mo gru ministers and later the princes of Rin spungs were revolting against the Phag mo gru pa leadership in Dbus, where they ruled until the end of the 16th century. Their lifetimes also coincide with the rise of the Dge lugs pa order, founded by Tsong kha pa (1357-1419), who enjoyed the patronage of the Phag mo gru pa.

[23] Tucci 1971: 192.

[24] Sangs rgyas rgya mtsho 1994 [1702]: 309; Shes rab rdo rje 1994.

[25] Tucci 1971: 192. In *Shel dkar chos 'byung* 46a (Wangdu and Diemberger 1996: 79), for example, debates of Bo dong Phyogs las rnam rgyal at Ngam ring chos sde are mentioned in the first half of the 15th century. During my research in Ngam ring, the monks of Ngam ring chos sde monastery proudly talked about the monastery's famous history of debate. They mentioned that Tsong kha pa (1357-1419) had debated at Ngam ring chos sde and that he had taught in its congregation hall. The debate between Bo dong Phyogs las rnam rgyal and Mkhas grub rje (1358-1438) was enthusiastically recounted by the monks, and is also mentioned by Shes rab rdo rje (1994). Bo dong Phyogs las rnam rgyal, who was extraordinarily versed in religious matters and philosophy, had become famous for winning any kind of debate. However, when he came to Ngam ring chos sde monastery he debated with Mkhas grub rje, who defeated him for the first time in his life. Bo dong Phyogs las rnam rgyal was so impressed by Mkhas grub rje's knowledge and debating skills, that he subsequently became his disciple and stayed at Ngam ring chos sde. This historical debating spot became the place where many hundreds of monks used to assemble for debates during summer time (Shes rab rdo rje 1994).

[26] Pan chen nags kyi rin chen (1384-1468) is generally known as Vanaratna and had travelled to Tibet three times and taught there extensively. For his biography see Roerich (1988: 797-804).

'major' and 'minor' sciences.[27] By the time he was 40, the fame of his scholarship spread. He wrote over a hundred books on the Tibetan medieval sciences, ranging from dharma to astrology.

Moreover, he reached special expertise in *gso ba rig pa*.[28] Byang pa rnam rgyal grags bzang had become very knowledgeable in medicine, and founded and propagated Byang lugs as a distinct medical school. He did so after thoroughly studying the *Rgyud bzhi*.[29] He critically reflected on the *Four Tantras*, debated and commented upon them, and wrote about various other medical and astrological topics (see Table 2.1.). Skal bzang 'phrin las considers Rnam rgyal grags bzang's commentaries on the *Rgyud bzhi* as outstanding, regarding their clarity and completeness and writes that Rnam rgyal grags bzang repeatedly quoted the *Rgyud bzhi* in his works and supplemented its explanations with his own view on a given topic (1997: 352, 353).

Rnam rgyal grags bzang had numerous followers, among them the Jo nang seat holder (Jo nang *gdan sa ba*) 'Jam dbyangs nam mkha' chos skyong, Byams pa gser mchog 'od dpal, Tsho sna ba bsam gtan rgya mtsho and Shangs ston kun dga' dpal ldan and others who carried on the tradition of this lineage. From among his disciples there are two who are considered as his main disciples in the field of medicine. They were Mi'i nyi ma mthong ba don ldan, the personal physician (*bla sman pa*) of Byang pa rnam rgyal grags bzang, and Lhun sdings legs grub dpal.

At the age of 81,

> once again in Lhun grub sding, he [Rnam rgyal grags bzang] pretended to be ill for about a month. [...]. In the wood sheep year of the 8th Tibetan 60 year cycle, i.e. 1475, on the 6th day of the 5th month, he left his human physical body, and all worldly puposes were perfected. The wisdom light of the Kālacakra teachings transformed him to go to higher realms. There was a rainbow, a rainfall of flowers and sweet fragrant smells were floating in all directions, and such phenomena occurred in immeasurable quantity.[30]

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[27] The five 'major' sciences or 'major fields of knowledge' are the science of healing, the science of words (i.e. linguistics), the science of dialectics and logic, the science of "construction" (including the physical sciences, engineering, fine arts etc.) and the science of inner meaning (i.e. the study of the Buddha's teaching). The five 'minor' sciences are poetics, synonymy, astrology, lexicography and the performing arts.

[28] More research is needed to specify who in terms of religious and medical matters had taught what to Byang pa rnam rgyal grags bzang.

[29] See Meyer 1992: 3; 1998: 29.

[30] Translated from Sangs rgyas rgya mtsho 1994 [1702]: 311.

None of Rnam rgyal grags bzang's children continued his medical lineage. Instead, it was passed on to two non-related amchi who themselves belonged to prestigious amchi lineages. One of them was Mi'i nyi ma mthong ba don ldan.

Mi'i nyi ma mthong ba don ldan

Mi'i nyi ma mthong ba don ldan (alias Byams pa dkon cog rin chen) was born in the first half of the 15th century. He is described as

> the victorious one, with a lotus in his hand, king of heavenly descended gods in human form, lord of black-headed people who are erect, son of magical god like Bsod nams rdo rje, who stands in the unpolluted bone-lineage of the Tibetan Dharmarajas (*bod chos rgyal gyi gdung*).[31]

His father was called Bsod nams rdo rje and descended from an amchi lineage reaching back to imperial times (Skal bsang 'phrin las 1997: 356). As a child, Mi'i nyi ma mthong ba don ldan showed extraordinary intelligence and compassion, which set him apart from his peers. Like Rnam rgyal grags bzang, he too had studied with the Indian teacher Pan chen nags kyi rin chen, when he visited Tibet. Mi'i nyi ma mthong ba don ldan also studied with Lo chen bsod nams rgyal mtsho,[32] Brang ti dpal ldan 'tsho,[33] and learned *gso ba rig pa* from Byang ba rnam rgyal grags bzang.[34]

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[31] Translated from Sangs rgyas rgya mtsho 1994 [1702]: 312.

[32] Lo chen bsod nams rgya mtsho was an Indian translator and scholar who, in the 15th century, stayed near Ngam ring. He died south of Lhun sdings. A *mchod rten* with his relics is located in a place called Sha ru. This *mchod rten* is highly revered by the local people who reconstructed it a few years ago, as it had been destroyed during the Cultural Revolution.

[33] The epithet Brang ti might identify him as descendant of a family lineage of physicians who according to Rechung (1972: 193) were proud of going back to Brang ti rgyal mnyes mkhar bu, a physician contemporary to G.yu thog yon tan mgon po the Elder (708-833). A person called Brang ti dpal ldan 'tsho byed is mentioned in Taube (1981: 55) as well as in Schaeffer's online bibliography (Schaeffer 2002) with one early 14th century incomplete manuscript with the title *Bdud rtsi snying po yan lag brgyad gsang ba man ngag gi rgyud kyi spyi don shes bya rab gsas rgyas pa.* The Brang ti tradition flourished in the city of Sa skya. Taube writes (1981: 53) that "the people of brang ti worked in the 'medicine town' (*sman grong* or also called *sman grong nyi thog*) ... of Sa skya". Note that Sman grong, 'village or hamlet of doctors' was thus used for Sa skya as well as for Lhun sdings.

[34] Skal bsang 'phrin las writes that "Mi'i nyi ma mthong ba bowed down before the dust of the feet of those eminent teachers, learned and studied the three vehicles, the four sections of *tantra* (*rgyud sde bzhi*), studied the root texts as well as its commentaries. He studied the eight branches of medicine in theory as well as in practice" (1997: 356).

Mi'i nyi ma mthong ba don ldan received teachings on the Tripitaka and studied the *Rgyud bzhi* as well as their commentaries. He got special oral transmissions (*snyan rgyud*) from Rnam rgyal grags bzang. In particular, he asked Rnam rgyal grags bzang about the medical texts *So ma ra dza* and *Zla zer*.[35] From his father, *Bsod nams rdo rje*, he got the empowerments to certain oral teachings of this particular lineage, called *Bka' gdad rgya'i chu'i lha mo'i sgrub skor* (*Empowerment for the Sadhana of the Goddess of Water*) and the *Snyan brgyud kyi byin rlab* (*The Blessing of the Oral Tradition*).[36] "Everything worthwhile he got from his father" (Sangs rgyas rgya mtsho 1994 [1702]: 313). From Brang ti dpal ldan 'tsho byed he requested the *Chu'i lha mo dang drang srong gi sgrub skor* (*Sadhana of the Goddess of Water and Rishi*) and other teachings. He wrote 11 books on *gso ba rig pa* (see Table 2.2.), out of which two, the *Khyad 'phags spyi sman gyi gter mdzod* and the *Ngo mtshar spyi sman*, according to Taube, were sources for Sangs rgyas rgya mtsho's *Lhan thabs*, where they are mentioned in the colophon (1981: 74).

Mi'i nyi ma mthong ba don ldan's fame and knowledge on all aspects of *gso ba rig pa* spread far and wide, and so also his contemporary Zur mkhar mnyam nyid rdo rje (1439-1475) came to know about him. At the age of 14 he asked Mi'i nyi ma mthong ba don ldan about his lineage. The latter gave a lengthy reply to Zur mkhar pa in which he stresses the purity of his lineage and his intentions in becoming an amchi (see Sangs rgyas rgya mtsho 1994 [1702]: 313-19).

Mi'i nyi ma mthong ba don ldan thus helped Byang pa rnam rgyal's lineage to flourish, while he must have combined what he learned from Byang pa with the ancestral teachings of his own lineage. He had a son,

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35 Sangs rgyas rgya mtsho (1994 [1702]: 313). The scholar Chandranandana from Cashmere, also called Pandita Zla ba dga' ba, could be the author of the medical texts *So ma ra dza* and *Zla zer.* Meyer writes that the *Somaradza* is a medical text that is said to have been known in imperial Tibet (9th century CE) (1995: 112). According to Meyer, this text is reputed to have been taught by the *Bodhisattva* Manjushri on the Wutaishan in China for the first time, and was later reworked by the second century master Nagarjuna (1995: 141). A Tibetan translation by Hashang Mahayana and Vairocana appears under the Tibetan title *Sman dpyad zla ba'i rgyal po* (see Schaeffer 2002). Thus *So ma ra dza' and Zla zer* could be one and the same text. According to the 12th text *Rnam thar bka' rgya cen* (or *Rnam thar med thabs med pa*) of the 12th century medical treatise *Cha lag bco brgyad*, it was Chandranandana who listened to the Buddha *Rig pa'i ye shes* when he first expounded the *Rgyud bzhi* in Uddiyana (Karmay 1989: 20). He then handed it down to Vairocana, who brought it to the attention of king Khri srong lde btsan (742-97).

36 Further research is needed to know what kind of teachings these were.

called Lha btsun bkra shis dpal bzang, who according to Yon tan (1988: 112) was the main representative of Byang lugs.

Lha btsun bkra shis dpal bzang

Lha btsun bkra shis dpal bzang was born between 1440 and 1450.[37] He was brought up by his grandfather Bsod nams rdo rje, and received extensive religious teachings from both his father and his grandfather. He also studied *gso ba rig pa*, and—like Mi'i nyi ma mthong ba don ldan—received the empowerments *Bka' gdad rgya'i chu'i lha mo' i sgrub skor* (*Empowerment for the Sādhana of the Goddess of Water*) and *Snyan brgyud kyi byin rlab* (*The Blessing of the Oral Tradition*) from his family. He studied sciences, and *sūtra* and *tantra* under Pan chen nags kyi rin chen, Lo chen bsod nams rgya mtsho, Sems dpa' chen po gzhon nu rgyal mchog, Mus chen dkon chog rgyal mtshan (1388-1469), Grub dbang thang sdong pa, Mkhas grub don yod dpal ba, Legs bshad bzang po, Chag lo thams cad mkhyen pa.[38] Byang pa rnam rgyal grags bzang is not mentioned as his teacher. Lha btsun bkra shis dpal bzang later requested layman's (*dge bsnyen*) vows from Pan chen Sa skya mchog ldan. He is said to have critically reflected on his teachers' instructions, which led him to teach, and to write four books, among them two commentaries on the *Rgyud bzhi* and one history of medicine (see Table 2.3).

Bsod nams ye shes rgyal mtshan

From an early age onwards, Bsod nams ye shes rgyal mtshan studied the ten fields of knowledge and *gso ba rig pa* 'at the feet' of his father (Sang rgyas rgya mtsho 1994 [1702]: 321; Yon tan 1988: 101). He received 'secret oral transmissions' (*man ngag*), memorised the *Rgyud*

37 Gerke (1999) suggests that Lha btsun bkra shis dbal bzang was born approximately in 1459. Her calculation is supported by Yon tan (1988: 100), when mentioning Grub dbang thang stong rgyal po as Lha btsun bkra shis dpal bzang's teacher. Thang stong rgyal po was the famous yogin type saint and engineer, who according to his biography—written in 1588 (see Tucci 1949: 163)—lived from 1361 to 1485. However, as this would mean a life span of 128 years, Tucci proposes that this saint must have lived from 1385 to 1464 (1949: 163), which would coincide with Lha btsun bkra shis dpal bzang's lifetime.

38 For the latter Yontan mentions a lifespan from 1197 to 1265 (1988: 100), which, however, seems unlikely given that *Lha btsun bkra shis dbal bzang* was born approximately between 1440 and 1450 and that he had met teachers who lived in the 13th and 14th century.

bzhi, studied the commentaries and was given the same empowerments as those mentioned above. Sangs rgyas rgya mtsho stresses that he received everything that Lha btsun bkra shis dpal bzang knew, without any reservations. Because of war in Byang rong, Bsod nams ye shes rgyal mtshan became the 'personal physician' (*bla sman pa*) of a member of the Rin spungs pa ruling family. In a place called Gtsang rong ral ldar he composed a history of medicine entitled *Gso rig khog 'bugs pad dkar rgyal pa'i nyin byed* which is mentioned in the *Account on Rare Literature* by A khu rin po che shes rab rgya mtsho, who considers Bsod nams ye shes rgyal mtshan to be the last physician of Byang lugs, chronologically speaking (see Taube 1981: 52). Bsod nams ye shes rgyal mtshan died in a place called 'Jag thang. He seems to have died at an early age and without leaving children behind[39] which explains why his father Lha btsun bkra shis dpal bzang while still alive, had to pass on the lineage to Lhun sdings bstan pa dar rgyal (Skal bsang 'phrin las 1997: 360; Yon tan 1988: 101, 102). Lhun sdings bstan pa dar rgyal was the grandson of Lhun sdings legs grub dpal and the second main disciple of Byang pa rnam rgyal grags bzang, about whom more is mentioned below.

Thus the two divisions of Byang lugs, which started from the two main disciples of Byang pa rnam rgyal grags bzang, Mi'i nyi ma mthong ba don ldan and Lhun sdings legs grub dba', merged (see Table 1). I shall now deal with the latter and his lineage, which is also referred to as Lhun sdings lugs.

Lhun sdings legs grub dpal and Lhun sdings lugs

Lhun sdings legs grub dpal, was born in the early 15th century into the lineage of Gnya' ba chos bzang reaching back to the 8th century. The latter's lineage history says that he was the eldest of five sons of Dharma king (*chos rgyal*) Dge ba 'dzin from the northern part of Kham, who was capable in dharma as well as in politics. Due to his compassion towards his subjects, this king was considered worthy of being carried on the neck (*gnya'*) and thus, according to Sangs rgyas gya mtsho's *Khog 'bugs* was called Gnya' pa. Gnya' ba chos bzang is said to have

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[39] Gerke (1999: fn. 26) writes that Byams pa 'phrin las (1991) mentions the '*Byang pa* brothers' (*byang pa sku mched*) as following the direct lineage of Lha btsun bkra shis dpal bzang, which I could not confirm in the literature. It is only Bsod nams ye shes rgyal mtshan who is mentioned as Lha btsun bkra shis dpal bzang's son.

been very handsome, endowed with unobstructed senses, and was religiously very devoted and intelligent. King Khri Srong lde btsan (8th century) heard about him and summoned him from Mdo Khams to Dbus, from where he ordered him to go to India to study, and in order to invite translators and scholars. After he had studied in India, he came back as a learned scholar. The king was very pleased with him, and venerated him as his teacher, and made him his personal physician (*lha rje*). According to the *Khog 'bugs*, he became the "head ornament (*btsug rgyan*) of the nine great scholars of medicine" (Sangs rgyas rgya mtsho 1994 [1702]: 322). Indeed, tradition has it that there were nine physicians at the court of Khri srong lde btsan, who are supposed to have hailed from India, Kashmir, Nepal, Dolpo, China, Iran and the Turkic Regions of Asia (Meyer 1995: 112), who partly account for the various foreign influences on *gso ba rig pa*. They are supposed to have founded nine respective teaching lineages.[40] According to the *Khog 'bugs*, Gnya' ba chos bzang had also been taught by Padmasambava.

However, out of these nine physicians, and many generations later, one person called Gnya' ba nam mkha' gzhon nu (of the *gnya' pa* lineage) came to G.ya ru byang, i.e. the 'Northern Right Horn Province'.[41] The local ruler (*byang bdag*) at that time, Ta dben or Brtan pa, offered him rights over people, tribes and monasteries in the area of Ya rong and Gtsang 'o lung. His son Gnya' bar rdo rje 'bum in turn served as personal physician of the ruler of Byang (*byang bdag po'i lha sman*) as well as his main confident (*phyag yog*). Gnya' bar rdo rje 'bum's son was Lha'i rgyal mtshan, who became very learned in *sūtra* and *tantra*, and eventually got into the position of the abbot of Byang Ngam ring monastery. He was also a doctor and politician and had a son called Dkon mchog gzhon nu. He became a great scholar in *gso ba rig pa* and

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40 Meyer 1995. As the only evidence of early medical texts that can be dated with certainty to the royal period (7th to 9th century) are few and short documents from the Dunhuang caves (see Blondeau 1972), I can by no means certify the existence and role of Gnya' ba chos bzang, who is supposed to have 'crowned' the group of nine court physicians of the Tibetan emperor Khri Srong lde btsan. However, we could understand the fact that in the *Khog 'bugs*, Lheg grubs dpal's ancestry is traced back to the imperial period, as a proof of the authority of his lineage. This might have made him worthy of becoming one of the two main disciples of the ruler of Byang Ngam ring. Note that it is said that also for his father Mi nyi ma thong pa thong ldan came from the 'bone lineage' of the Tibetan religious kings.

41 The 'Right Horn Province' is an old geographic term for an area including today's Ngam ring in western Gtsang.

'*sngags rnying ma*' and was the personal physician of Theg chen chos rje kun bkras pa (1349-1425).

Dkon mchog gzhon nu's son was Legs grub dpal, who received his first medical teachings from his father, according to the tradition of the *gnya'* lineage. He later studied from Rigs ldan Byang pa rnam rgyal grags bzang who used to call him *bu chen* ('great son' or 'great disciple') and who empowered him to keep his lineage. Lhun sdings legs grub dpal had a son called Lhun sdings shes rab dpal ldan.

Lhun sdings shes rab dpal ldan

When Lhun sdings shes rab dpal ldan was born, many auspicious signs appeared. His father took him to Byang pa rnam rgyal grags bzang to obtain a name for him. The given name was Padma srid thar,[42] but later the boy became known as Shes rab dpal ldan.

Shes rab dpal ldan's teachers included the famous Indian teacher Pan chen nags kyi rin chen, who had visited Tibet for the third time in 1453 (cf. Roerich 1988: 801). Shes rab dpal ldan was given various religious teachings, among them the empowerment teachings of the Kālacakra. From Thang stong rgyal po he received extensive teachings, and eventually he became his chief 'spiritual son' (*thugs sras*).

Yon tan, writing about Lhun sdings legs grub dpal and his subsequent lineage holders, calls this tradition 'Byang pa Lhun lding lugs' (1988: 102). Also, Skal bsang 'phrin las writes that Lhun sdings legs grub dba' started the Lhun sdings tradition within Byang lugs (1997: 351). This suggests that Lhun sdings lugs was a sub-school of Byang lugs, right from the first generation after Byang pa rnam rgyal grags bzang.[43]

Lhun sdings shes rab dpal ldan's son called Lhun sdings dge mas continued his father's lineage.

[42] This is the name which appears in Yon tan's lineage tree of Byang lugs (1988: 107).

[43] As they become called Lhun sdings lugs, and their lineage holders carried the epithet Lhun sdings, this might be the reason why neither Byang lugs physicians, nor their work are mentioned in the *Thob yig* of the Mongolian lama Jaya Paṇḍita (see Taube 1981: 52). Sangs rgyas rgya mtsho also more often refers to the "methods (of the doctors) of Lhun sdings" than to Byang lugs (Taube 1988: 52).

Lhun sdings dge mas

Lhun sdings dge mas continued the tradition of *gso ba rig pa* and eventually became the 'personal physician (*bla sman* [*pa*]) of the ruler of G.ya ru byang. Not more than that is known about him, apart from that he had a son called Bstan pa dar rgyas.

Lhun sdings bstan pa dar rgyas

Lhun sdings bstan pa dar rgyas was born in the late 15th century. He also showed extraordinary qualities in early childhood, i.e.

> he was endowed with compassion, wisdom, perseverance and religious devotion, because the obscuration of karma were all removed right from his childhood (translated from Sangs rgyas rgya mtsho 1994 [1702]: 324).

He had a very sharp memory, and "in the time of putting on one's clothes could memorise an arrow length of scripture paper" (*ibid.*). He memorised the whole *Rgyud bzhi*, and the *Snying po bsdus pa'i rgyud* and on the latter teachings took an exam with the ruler of La stod Byang.

As the son of Lha btsun bkra shis dpal bzang, Bsod nams ye shes rgyal mtshan had passed away at an early age in a place called 'Jag thang, the head quarter of the Rin spungs clan, and as the latter had no children Lha btsun bkra shis dpal bzang "was thinking it would be a great loss of the stream of wisdom" if the lineage would not be continued, and in loyalty with the Byang pa rulers, sent a messenger to the ruler of Byang. He requested the ruler to choose somebody whom he would know of as being very intelligent as well as trustworthy to be a good personal physician so that he can save the lineage and transmit his knowledge (Sangs rgyas rgya mtsho 1994 [1702]: 324). Accordingly, and as requested, Bstan pa dar rgyas was sent. Bstan pa dar rgyas fulfilled both requirements, because of his *bla* sman kyi rgyud, i.e. his lineage being the ruler's personal physician's family, and because of his fitting intelligence. Since that time, Bstan pa dar rgyas was studying both the *sūtra* and *tantra* at the feet of his master Lha btsun bkra shis dpal bzang and focused in particular on all the oral transmissions of the tradition of *gso ba rig pa*, for example, the *Man ngag drang srong yid las skyas*. After this he received, unlike the predecessors of his *gnya'* clan, the *Snyan brgyud zhal shes* (*Wisdom which is exclusively passed*

on orally). And again the *Khog 'bugs* stresses that: "everything that Lha btsun bkra shis dpal bzang knew, he passed on to Bstan pa dar rgyas" (Sangs rgyas rgya mtsho 1994 [1702]: 325).

As already mentioned above, here the previously two divisions of Byang lugs, starting with Mi'i nyi ma mthong ba don ldan and Lhun sdings legs grub dpal became unified (see Table 1, lineage tree). Lhun sdings bstan pa dar rgyas passed on the now unified lineage to his son, called Bsod nams chos 'phel.

Bsod nams chos 'phel

Almost nothing is mentioned about Bsod nams chos 'phel in Sangs rgyas rgya mtsho (1994 [1702]: 325) and not more than his name in Yon tan (1988: 106, 107). Sangs rgyas rgya mtsho only writes that he was extraordinarily perfected in pulse diagnosis and that he had a son called Lhun sdings bdud rtsi 'gyur med to whom he passed on his lineage.

Lhun sdings bdud rtsi 'gyur med

Lhun sdings bdud rtsi 'gyur med was born in the mid 16th century; he was educated by his father and received medical empowerments from him. Lhun sdings bdud rtsi 'gyur med became a great scholar of medicine and worked as 'personal physician' (*bla sman pa*) of Tāranātha Kun dga' snying po (1575-1634).[44] Lhun sdings bdud rtsi 'gyur med was a contemporary of Zur mkhar blo gros rgyal po (1509-1579), the well-known proponent of Zur lugs and outstanding scholar, who in 1542 had discovered a handwritten *Rgyud bzhi* and in 1546 encountered the carved wood blocks of the *Rgyud bzhi* at Gra thang monastery in Eastern Tibet. Zur mkhar blo gros rgyal po redacted this so-called *Gra thang rgyud bzhi*, the new edition of which was published in 1640. Lhun sdings bdud rtsi 'gyur med, who, I suppose, resided at least part-

[44] Tāranātha was head of the Jo nang sect, founded by Dol po pa Shes rab rgyal rtshan (1292-1361) (Stearns 1999). Their centre was Jo nang Phun tshogs gling (see map). Tāranātha was a great polygrapher and in 1621 restored the *mchod rten* of Jo nang (constructed ca. 1354), with the assistance of the regent of Byang and Bsam grub rtse (Tucci 1949: 196), as they were eager to counter the rise of the Dge lugs pa. After Tāranātha's death in 1634, coinciding with the rising power of the 5th Dalai Lama, Phun tshogs gling was transformed into a Dge lugs pa establishment and was renamed Dga' ldan phun tshogs gling (for a description of the site, see e.g. Tucci 1949; Chan 1994).

ly in or near Jo nang Phun tshogs gling, systematised and thoroughly edited this *Gra thang rgyud bzhi* edition (Gerke and Bolsokhoeva 1999: 31, 32). He oversaw the carving of the new set of wood blocks for this edition, which came to be called *Rtag brtan rgyud bzhi* after the monastery Rtag brtan dga' ldan phun tshogs gling, where it was published in 1640.[45] This monastery became called Rtag brtan dga' ldan phun tshogs gling only after its conversion from Jo nang to Dge lugs.[46]

Lhun sdings bdud rtsi 'gyur med also composed the *Gso dpyad kyi lag len dgos 'dod kun 'byung*[47] which was used in two famous commentaries, the *Vaidurya sngon po* and the *Lhan thabs* by Sangs rgyas rgya mtsho (Taube 1981: 52, 74). Lhun sdings bdud rtsi 'gyur med's son and lineage holder (*rigs sras*) was Lhun sdings rnam rgyal rdo rje.

Lhun sdings rnam rgyal rdo rje

Lhun sdings rnam rgyal rdo rje, who was born in the second half of the 16th century, also studied all the ten fields of knowledge in general, and *gso ba rig pa* in particular. He was empowered to continue the lineage of his father. He authored the medical text *Rkyang sel skor 'cho byed spyi la dris pa rdo rin rgyan mchog*.[48]

He was famous for his erudition, and eventually came to the attention of the Fifth Dalai Lama Ngag dbang blo bzang rgya mtsho (1617 - 1682). Ahmad, in his biography of the Fifth Dalai Lama and in the account of Sangs rgyas rgya mtsho's ministry from 1679 to 1682, translates an entry for the year 1680:

> Because Rnam rgyal rdo rje of (the medical monastery called) 'Tsho byed Lhun sdings was very learned in the (arts of) healing and diagnosing, he had a stream of medical students and a (flourishing) practice of medicine for the benefits of others. In order to provide for the students in

[45] This monastery was indeed famous for its printing press, where large numbers of historical and religious texts were printed (see Chan 1994: 864); and as it appears, it also played a major role in the publication of medical texts.

[46] Ahmad (1999: 269). I was not able to visit Phun tshogs gling and thus do not know whether there are still medical texts to be found. It would certainly be a suitable field site to conduct further research on the regional history of *gso ba rig pa*. Several people in Ngamring mentioned that Phun tshogs gling, until the 1950s, had been a good place to study *gso ba rig pa*.

[47] See bibliography under Bdud rtsi 'gyur med 1989.

[48] This book was one of the sources used by Sangs rgyas rgya mtsho in his commentaries *Vaidurya sngon po* and *Lhan thabs* (Taube 1981: 52).

> accordance for the teaching of medicine and in order to provide for the students in accordance with the Lord Lama, he (Rnam rgyal rdo rje) was granted 100 *mkhar ru khals* of grain annually, each (year), for as long as he was in good health (i.e. for as long as he lived) (Ahmad 1999: 328).

He later also employed Lhun sdings rnam rgyal rdo rje to teach Byang lugs to his physicians (Skal bsang 'phrin las 1997: 351)[49] and also taught the second and third *tantra* to the Fifth Dalai Lama's regent, Sde srid sangs rgyas rgya mtsho (1653-1705). Among the Regent's various medical works, he composed a book entitled *Drang thig srid sgrub kyi mda'* which is a reply to questions of his teacher Lhun sdings rnam rgyal rdo rje (see Taube 1981: 77 and Czaja this volume). Sangs rgyas rgya mtsho highly revered Lhun dings rnam rgyal rdo rje's expertise, who was, at that time, without rival concerning medical doctrine, identification of plants, channels, anatomy, and the metaphors of 'unfolded trees' (*sdong 'grems*), according to the *Gso rig sman gyi khog 'bugs*. Gerke (1999: 20) and Meyer (1992: 6) also note that Lhun sdings rnam rgyal rdo rje was a thangka painter and that he had reproduced some anatomical figures which came from his father Lhun sdings bdud rtsi 'gyur med. Lhun sdings rnam rgyal rdo rje also beautifully painted the sixth and seventh plate of the Lhasa edition, being part of a famous series of 79 medical thangka. With the help of these thangka the regent Sangs rgyas rgya mtsho aimed at clarifying his commentary on the *Rgyud bzhi* "as clearly as one would see a myrobalan fruit held in the palm of the hand" (Meyer 1992: 7). Meyer, quoting from the *Vaidurya sngon po*, writes that Rnam rgyal rdo rje himself traced

> the topographical lines of the channels (*rtsa thig*) and, based on them the channels which are important for the points of application of moxibustion, minor surgery, and blood lettings, as shown clearly in the additional paintings (Meyer 1992: 6).

In summary, judging from the contemporary sources, one can assume that Lhun sdings rnam rgyal rdo rje must have been a great medical authority at the time. It is also reported, that he had been vividly

[49] Around the time of the Fifth Dalai Lama, there were two other followers of Byang lugs. They were called Bstan dzin rgyal po, who was also a personal physician of the Fifth Dalai Lama, and his son Mkhas dbang dar rgyas, who initiated the publication of the newly edited version of the *Gra thang rgyud bzhi* by Lhun sdings bdud rtsi 'gyur med, printed in Phun tshogs gling (Gerke and Bolsokhoeva 1999: 32). This edition of the *Gra thang rgyud bzhi* was again printed in Lhasa in the water tiger year of 1662, and according to Yontan (1988: 298) as cited in Gerke and Bolsokhoeva (1999: 32), is considered the most authoritative edition of the *Rgyud bzhi*.

engaged in ongoing medical debates, even with Sangs rgyas rgya mtsho (Meyer 1992: 6). He once, for example, also refuted the *materia medica* of Zur mkhar blo gros rgyal po's *Mes po'i zhal lung* (Meyer 1992: 6), which was one of the most authorative works of the Zur School.

BYANG LUGS AND SANGS RGYAS RGYA MTSHO

According to Yon tan's lineage tree Sangs rgyas rgya mtsho is considered to be the last lineage holder of Byang lug and Zur lugs (1989: 107). He had learned with the proponents of both schools, and, unlike the Fifth Dalai Lama, seems to have been unbiased towards them. Given the extent of his writings and his intellectual capacity, one can assume that he indeed was capable of unifying the prevailing schools on a theoretical level. Indeed, Sangs rgyas rgya mtsho himself wrote on the inventory chart (*dkar chag*) of the Fifth Dalai Lama's stupa, that he had united the line of transmission of medical teachings, which had been divided up after Brang ti[50] in the first half of the 13th century (Meyer 1992: 7).

In the climate of the political as well as religious unification of Tibet, his statement is not surprising. Obviously the rise to power of the Dge lugs pa was also an important factor to level doctrinal incongruences of the different medical schools, given that, for example, some of their lineage holders were closely related to different religious sects and schools.[51]

The question, however, arises as to how different the schools actually had been before their supposed unification by Sangs rgyas rgya mtsho. Oral sources as well as secondary literature confirm that both

[50] 'Brang ti' is the name of a famous medical lineage, whose origins in Tibetan historiography are sometimes traced back to the imperial period. Beckwith (1979: 303 f, 305 f.) translating Sangs rgyas rgya mtsho's *Khog 'bugs*, writes that the Brang ti school goes back to their first teacher Biji Tsanpasilaha, who was the personal physican of king Khri lde gtsug brtsan (commonly known as Mes 'ag tshoms, d. 755 CE). However, what Sangs rgyas rgya mtsho actually meant by writing that he united the medical lineages which had been devided after Brang ti, is not yet clear. See Olaf Czaja's contribution to this volume.

[51] Note that apart from Byang lugs and Zur lugs, there were also other medical schools prevailing in the 16th and 17th century in Tibet. For example, there was Gong sman lugs, whose founder was Gong sman pa dkon mchog bde legs. His son Kong sman dkhon mchog 'phan dar was born in 1511, and became the main representative of the Gong sman lugs, whose proponents practised at Sa skya and later in Shigatse (see Taube 1981: 67, 68; Skal bsang 'phrin las 1997: 347).

schools accepted the *Rgyud bzhi* as their root text. However, there were differences at the level of ordinary physiology, identification of plants, and certain treatments—yet these remain to be researched and compared in detail. From at least the 16th century, if not before, there must have been considerable exchange between the two schools, as we know that Zur mkhar blo gros rgyal po, for example, got initiations from Byang lugs and Zur lugs physicians.[52]

In her comprehensive account of Byang lugs and Zur lugs Gerke concludes that Sangs rgyas rgya mtsho united Byang lugs and Zur lugs after two hundred years of their peaceful coexistence. In comparison with, for instance, Zur mkhar blo gros rgyal po, Gerke suggests that Sde srid sangs rgyas rgya mtsho had been politically influential enough to unite the two schools which after him seem to have ceased to exist as distinct traditions (Gerke 1999).

What made it possible for Sde srid sangs rgyas rgya mtsho to unify the prevailing medical schools? Firstly, he had acquired an unprecedented deep and comprehensive knowledge of the different schools of his time, and secondly, he possessed political power. It seems, however, that the regent not only wanted to rule Tibet in a strictly political sense, but also intended to create a cultural hegemony in a variety of areas. This was mirrored in his efforts to redefine time (astronomy and astrology), space (ritual), the monastic curriculum, and last but not least medicine. He was able to standardise medical education and practice by establishing the Lcag po ri medical college on the Iron Hill in Lhasa in 1696, and it was not without reason that he chose such a significant location opposite the Potala palace. More generally speaking, his legacy has to be seen as a continuation of the efforts of the Dga' ldan pho brang gzhun, starting in 1652, to consolidate a unified Tibetan state, by adapting and incorporating diverse religious, political and, as we have seen, also various medical traditions.

However, the oral evidence I presented above suggests a slightly different view, and actually raises the question, whether the Byang and Zur traditions continued after Sangs rgyas rgya mtsho. To answer this question we need to compare the oral and textual sources.

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[52] Also, one of his works is a collection of questions to a Byang physician Dkon mtshon phan dar, and another one is about 'Byang pa's lecture' (*Byang pa'i bka' sgrub*) (Yon tan 1988: 115).

AGREEMENT BETWEEN ORAL AND TEXTUAL SOURCES—A COMPARISON

First of all, I shall point out how the different sources I have elicited above support each other's argument. In terms of location, they all place Byang lugs' origin as well as the main area of its dissemination in today's southern Ngam ring county, with a particular focus on the town of Ngam ring and the village of Lhun sdings, as well as Phun tshogs gling, though the latter to a lesser extent. The fact that one descendant of this lineage belongs to the Sman grong of Lhun sdings and that he remembers the old residence and library where their lineage holders had lived for many generations, confirms that the epithet 'Lhun sdings' refers to the village of Lhun sdings to the northeast of Ngam ring. The note in Ahmad's translation of Sangs rgyas rgya mtsho's description of his ministry, even speaks of "(the medical monastery called) 'Tsho byed Lhun sdings" (1999: 328), where Lhun sdings rnam rgyal rdo rje had received an annual amount of grain for himself and his students. Thus it is very likely that in this house a considerable number of medical texts was kept, not only at Rnam rgyal rdo rje's time (i.e. end of the 16th, beginning of the 17th century), but that they were preserved there until the 1960s. That was the time mentioned by my informants from Lhun sdings in which the destruction of the textual heritage as well as the building of the Sman grong took place. Many informants have confirmed the existence of the previous Sman grong house, and of the long tradition of medical practice there.

The ethnographic data also support the texts in terms of regionality: the places where the teachers of Byang lugs proponents had either lived or had visited, and the places where their disciples were born or had resided were relatively close to one another. One evidence for this is a small stupa of Lo chen rin po che in Sha ru, which is situated a one hour walk away, south of Lhun sdings. The villagers' account refers to Lo chen rin po che visiting this area in the 15th century while the textual sources point to him being the teacher of Mi'i nyi ma mthong ba don ldan and Lha btsun bkra shis dpal bzang, both of whom were born in the first half of the 15th century in this area. Other sources that can be quoted as evidence, are the accounts of the monks of Ngam ring chos sde, concerning the visits and debates of Bo dong Phyogs las rnam rgyal, which are recorded in the literature as well. Moreover, there is the relative regional closeness of Lhun sdings and Jo nang Phun tshogs gling, where doctors of Lhun sdings lugs had been working and con-

tributing to the new edition of the *Rgyud bzhi* which was reprinted at the Rtag brtan dga' ldan phun tshogs gling monastery. Different textual sources confirm Lhun sdings bdud rtsi 'gyur med as being influential in this new edition of the *Gra thang rgyud bzhi.* Furthermore, the different sources confirm Byang pa rnam rgyal grags bzang's lifetime to be in the seventh Tibetan 60-year cycle (1387-1447).

When looking at the texts and the way people talk about Byang lugs, it is always set it in the context of Zur lugs, which started half a century after Byang lugs. Regarding the name of the schools, the various sources also use Byang-Zur for the two schools, suggesting the temporal sequence, which is correct, as well as their relatively peaceful coexistence (Gerke 1999: 23). The oral and textual evidence leaves no doubt that Byang lugs is the 'Northern School', not so much in relation to the 'Southern School', but rather because it refers to Byang Ngam ring or La stod Byang, i.e. Ngam ring in the myriarchy of Byang or Northern La stod, while Zur lugs refers to Zur mkhar la thog, the place in eastern Dwags po where the Zur lugs founder Zur mkhar mnyam nyid rdo rje (1439-1475) was born. We thus can conclude that Byang lugs derives its name from its place of origin and dissemination in La stod byang, and that in relation to its geographical dissemination, Zur lugs later became the so-called 'Southern School'. This north-south division of the schools' origins and disseminations are correct regional geographical classifications of the places where the two schools originated and were practiced, although I doubt that their practice has been limited to those areas.

DISAGREEMENT OF THE ORAL AND TEXTUAL SOURCES—DISCUSSION

Most obviously, oral and textual sources disagree regarding the continuity of the lineage. Oral history suggests that Byang lugs or Lhun sdings lugs was directly passed down until the end of the 19th century, when the amchi who held this lineage died at a young age and 'the lineage was cut'. However, the textual sources and the work of Sangs rgyas rgya mtsho himself suggest, that Byang lugs and Zur lugs were unified by Sangs rgyas rgya mtsho in the 17th century. We may understand these divergences of the different sources in the following way: it seems likely that the differences of the schools in terms of medical theory and practice (physiology, *materia medica* etc.) became less important by

the 16th century, when there was increasing exchange between the schools, and more so by the end of the 17th century, when Sangs rgyas gya mtsho established a more standardised education at the Chagpori Medical College in Lhasa.

However, I would suggest that in the 17th century the practices and stories of Byang lugs or Lhun sdings lugs did *not* end, and the efforts of the Tibetan government to centralise and standardise medicine had only been partially successful. As Gerke (1999) already mentioned, occasionally family traditions carried on Byang lugs and Zur lugs. This seems to have been the case with the Sman grong of Lhun sdings. Tshe ring thob rgyal reports for Lhun sdings lugs, that until the end of the 19th century the lineage was directly passed on with at least one representative, who was his father's mother's brother. Even though at that time 'the lineage was cut', and he was not taught within this lineage, he studied *gso ba rig pa.* He also identifies himself as a descendant of the lineage of Byang lugs founder Byang pa rnam rgyal grags bzang. He and the people he lives with are considering an amchi career for one of their sons, in order to continue their amchi lineage again. Note that it is still the boy and not his two sisters for whom those plans are made.

Other oral evidence, especially emerging from the interviews with the two doctors whom I had met in Shigatse, but who originally came from Ngam ring, support that Byang lugs was a school of Tibetan medicine, but that it ceased to exist long ago, and was of no major importance in recent times. Only, in the early 1990s, when it was discussed whether an independent hospital for Tibetan medicine should be constructed in Ngam ring, the historical importance of Ngam ring as the 'homeland of Byang pa rnam rgyal grags bzang' was stressed.

Concluding Remarks

We can now locate the area of origin and dissemination of Byang lugs in today's southern Ngam ring. This is the place where it was passed on for at least two hundred years (during the 15th and 16th centuries) and according to oral history until the 19th century. This seems very likely, as only few amchi could actually study at Chagpori in Lhasa. Moreover, with the importance attributed to *rgyud* in Tibetan culture and society it seems very unlikely that the transmission of medical knowledge, including particular knowledge about plants and minerals which are

locally available, as well as special practical techniques, would have stopped, unless a lineage holder had no chance to pass on his knowledge.

We have also seen that all proponents of Byang lugs have actually learned from *various* teachers and experts, hailing from different religious as well as medical backgrounds. Byang lugs was thus not linked to a certain sect and seems to have been absorbed pragmatically. This means that different medical traditions that were passed on in various lineages became merged in the work of the representatives of Byang lugs, and much research would be needed in order to find out how this is reflected in their writings and their actual practice. For example, whether correct or claimed, both of Byang pa rnam rgyal grags bzang's main disciples studying *gso ba rig pa* from him are attributed to lineages going back to the imperial time, one of them even going back to one of the nine court physicians of king Khri srong lde btsan (8th century). Thus, they had received different oral initiations, and knowledge, on different texts. After the first two disciples of Byang pa, *gso ba rig pa* was passed on from father to son, as opposed to the Zur schools where *gso ba rig pa* was mainly passed down from uncle to nephew. Only when the lineage holder Bsod nams ye shes rgyal mtshan died at a young age and had no children, his father again passed on his knowledge to his non-kin related disciple Lhun sdings bstan pa dar rgyas, who represented the second branch of Byang lugs. He and his family served as personal physicians of the rulers of Ngam ring. With the person of Byang pa rnam rgyal grags bzang another figure in the history of Tibetan medicine emerges, who was a politician of high rank, religious authority as well as a scholar and doctor at the same time.

However, looking at the data presented for an overview of Byang lugs, I really want to stress the preliminary character of my research. There is still a great deal to be done. I would suggest to look for further textual evidence on Byang lugs, which might be available in Ngam ring, or elsewhere, including the texts written by Byang lugs' proponents (see Table 2.1., 2.2., 2.3.) as well as *rnam thar*, for example the one of Byang pa rnam rgyal grags bzang (2001), written by Kun dga' grol mchog in the 16th century.

A more complete translation, of Sangs rgyas rgya mtsho's *Gso rig sman gyi khog 'bugs*, of Zur mkhar blo gros rgyal po's and Lha btsun bkra shis dpal bzang's medical historiographies, including philological

analysis, and an investigation into the sources used therein, would proof very valuable.[53] Inquiries into the oral history of this area, which drew my attention to Ngam ring in the very first place, will be important too, as this can ascertain or contradict evidence derived from text, and can draw our attention to phenomena simply not mentioned in the texts.

Spanning across history, there are common characteristics of the transmission of *gso ba rig pa* in the 15th and 16th centuries and today's Ngam ring county. The amchi in the past have mostly learned from several different teachers, ranging from their own fathers and uncles to non-related medical and religious teachers, and continue to do so today. Amchi in today's Ngam ring who belong to a lineage, be it of kinship or of a teacher-disciple relationship, remain in high demand and are granted special status in society. Some of Ngam ring's contemporary amchi have also passed on their knowledge to students in informal ways, or plan to do so. However, most amchi nowadays receive their education in one of the medical colleges in Lhasa or elsewhere, which does not mean that they do not study under well-known lineage amchi on a private basis or when, for example, working in the same hospital.[54]

To conclude, I would like to point out that there were diverse ways in which *gso ba rig pa* was transmitted throughout the centuries. Those ways have changed with their social and political contexts, and transmission of *gso ba rig pa* underwent various phases of standardisation. Hence, the endeavour to standardise, unify and formalise knowledge is not an exclusively recent phenomenon and also, it seems to me, affects urban areas more than rural areas. However, despite the centralised and powerful institutions and their political interest to control the transmission of medical knowledge, amchi who belong to lineages, be it of kinship or otherwise, remain in high demand in contemporary Ngam ring.

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[53] See Olaf Czaja's contribution in this volume.

[54] Given the limited scope of this article, I would like to refer to my two MPhil and my MSc dissertations dealing with historical as well as anthropological aspects of *gso ba rig pa* practices and their transmission in Ngam ring in more detail (Hofer 2004, 2005).

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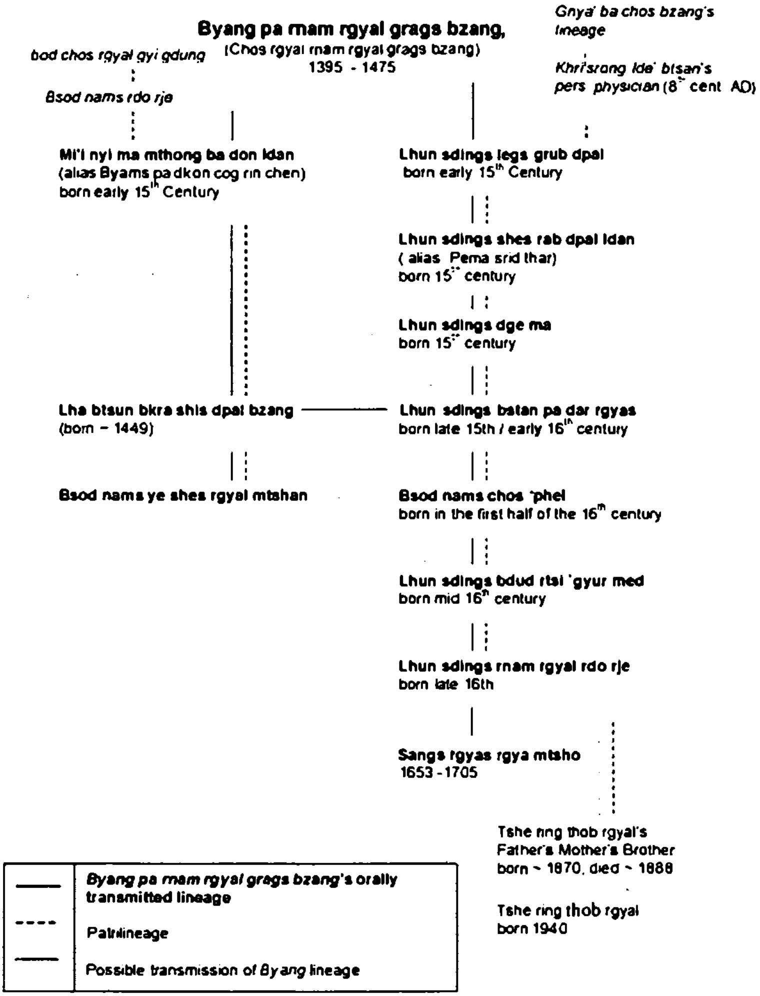
Table 1: Lineage tree of the Northern School and Lhun sdings School*



* This lineage tree is based on Sangs rgyas rgya mtsho 1994 [1702], Skal bzang 'phrin las 1997, Yon tan 1998 and my ethnographic research in Ngamring in summer 2003. Note that years of birth of Byang lugs proponents need futher research and are just meant to give a rough idea of their lifetimes.

Table 2.1: List of medical works by Byang pa rnam rgyal grags bzang (1395-1475)[55]

1. *Rtsa ba'i rgyud kyi bshad pa rgyud don gsal byed sgron ma* (*Commentary on the Root Tantra: the Lamp that Illuminates the Meaning*)
2. *Bshad rgyud kyi rgya cher 'brel pa bdud rtsi'i chu rgyun* (*Great Commentary on the Explanatory Tantra: the Stream of Ambrosia*), written in 1463, reprinted in 2001
3. *Ti ka chung don gsal* (*Minor Commentary on the Root Text*)
4. *Phyi ma rgyud kyi dka' 'krel dgos 'dod 'byung ba* (*The Wish-fulfilling Commentary on the Different Broader Aspects of the Last Tantra*)
5. *Yongs gtad kyi 'grel pa tshig don rnam par gsal ba*
6. *Yan lag brgyad pa thams cad kyi snying po bsdus pa yid bzhin nor bu rin po che*[56] (*The Wish fulfilling Condensed Essence of the Eight Branches*, in 120 Chapters)
7. *Sman gzhung rin chen sgrom bu* (*Medical Fundamentals: the Small Treasury Chest*)
8. *Rtsom pa chung ba'i rgyud bzhi'i dka' 'phrang mun sel* (*A Minor Compositions on: Dispelling the Darks Aspects of the difficult Pathways of the Rgyud bzhi*)
9. *Gso thabs sum brgya rdug cu'i ngos 'dzin* (*Identifying 360 Ways of Healing*)
10. *Rtsa bshad gsal ba'i sgron me* (*The Lamp to Clarify the Pulses*)
11. *Srog btsod nad dgu'i dbye ba* (*Classification of Nine Life taking Illnesses*)
12. *'Tsho byed rnams la snying nes brtse ba'i 'phrul gyi yig chung* (*Advice from the Heart to Fellow Doctors*)
13. *Seng ge rtse 'tsho byed kyi dris lan* (*Reply to Seng ge rtse 'tsho's questions*)

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[55] Sangs rgyas rgya mtsho 1994 [1702]: 310, Skal bzang 'phrin las 1997 and Yon tan 1988 mention thirteen works on medicine by Byang pa rnam rgyal grags bzang. Taube (1981: 51), referring to Akhu Rinpoche's *Account On Rare Literature* also writes that Byang pa rnam rgyal grags bzang has authored 13 books with medical content and commentaries on parts and the whole of the *Rgyud bzhi*. Additionally Dung dkar blo bzang 'phrin las (2002: 1478) mentions the *Grub rtsis chen mo* (*Great Astrology based on the Kālacakra*), *Gsal byed yid bzhin nor bu'i phring pa* (*Garland of Wish-fulfilling Light*) and the *Gza' 'dzin brtag pa dka' ba'i gnas shin tu rgyas par bshad pa* (*Detailed Explanations on the Calculation of the Eclipse*), my translation of Tibetan titles. Two of these texts, one as a manuscript as well as a print, can be found in the archives of Drepung (No. 016856, 016859, 016860, Dpal brtsegs bod yig dpe rnying zhib 'jug khang 2004: 1496).

[56] This book is also mentioned by Rechung 1973: 21. Taube (1981: 77) mentions it as a source for Sangs rgyas rgya mtsho's *Vaidurya sngon po*.

Table 2.2: List of works by Mi'i nyi ma mthong ba don ldan[57]

1. *Thugs las 'khrung pa'i legs par bshad pa 'ang gso dpyad kyi rgyal po* (*The King of Medicine*)
2. *Dpal ldan rgyud bzhi'i 'grel pa bkod pa rnam bzhi* (*Four Kinds of Commentaries on the Rgyud bzhi*)
3. *Rgyun rnam bzhi mngon pa rtogs pa'i gsol 'debs*
4. *Rgyud bzhi'i rnam nges sam bka' sgrub* (*The Truth of the Rgyud bzhi*)
5. *Ma la ya'i dka' 'grel 'dod 'jo che chung*
6. *Khyad 'phags spyi sman* (*Special and Common Medicines*)
7. *Ngo mtshar spyi sman* (*Particular and General Medicines*)
8. *Rims bcos mi la srog sbyin* (*Therapy for rims—Granting life to people*)
9. *Bshad rgyud le'u bzhi pa'i 'grel pa gnas lugs rab gsal* (short: *Gnas lugs rab gsal*; *Commentary on the Fourth Chapter of the Explanatory Tantra, called Clear image*)
10. *Rtsa mdo'i 'grel pa snyan rgyud rdo rje'i tshig rkang* (*Diamond Lines of the Oral Tradition—Commentary on the main Sutra*)
11. *Gces bsdus rin chen phreng ba* (*The Precious Rosary of Quotations*)

Table 2.3: List of works by Lha btsun bkra shis dpal bzang[58]

1. *Bshad rgyud kyi 'grel pa legs bshad nor bu* (short: *Legs bshad nor bu*; *Commentary on the Explanantory Tantra: the Gem of Didactic Say ings*)
2. *Phyi rgyud 'grel pa dgos 'dod 'byung ba rin po che'i bang mdzod* (short: *Klags pa kun shes*; *A Commentary on the Final Tantra*)
3. *Khog 'bugs 'dzum dkar bzhad pa'i nyi ma* (*A History of Medicine: the Smiling Sun*)
4. *Rgyud bzhi'i rnam nges dpag bsam ljon shing*

[57] Sangs rgyas rgya mtsho (1994 [1702]: 319), Skal bzang 'phrin las (1997: 357) and Yon tan (1988: 99, 100) mention the titles of eleven books, while A khu rin po che shes rab rgya mtsho in his *Account on Rare Literature*, as cited by Taube (1981: 52), mentions twelve books authored by Mi'i nyi ma mthong ba don ldan.

[58] Three of Lha btsun bkra shis dpal bzang's works are mentioned in Rgya mtsho [1702] 1994: 321, Taube 1981: 52 and Yon tan 1988: 101.

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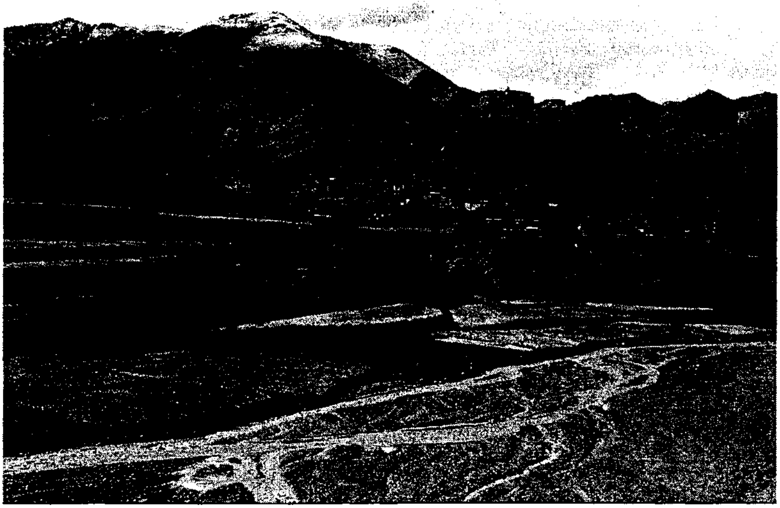

Plate 1: Lhun sdings with monastery

Plate 2: Tshe ring thob rgyal and his grandchild in the Sman grong house in Lhun sdings

EMBRYOLOGY AND EMBODIMENT IN TIBETAN LITERATURE: NARRATIVE EPISTEMOLOGY AND THE RHETORIC OF IDENTITY

FRANCES GARRETT

In this article I will focus on the presence of embryology in Tibetan literature as it occurs from the twelfth century through the sixteenth century. First I will summarise the sources for embryological information that Tibetan writers had available to them in the eleventh to twelfth centuries. Where did they learn about how humans are conceived and grow, and what sources influenced them most? After introducing a few Tibetan literary sources in which we find embryology addressed, I will discuss the relationship between how we read such embryological narratives, and what we understand them to say. I will preface this by noting that embryology, physiology and anatomy, as sub-branches of the discipline of biology with specific definitions and histories in Euro-American thought, have no direct terminological or conceptual correlate in Tibetan. What I am calling 'embryology' in this article is in Tibetan literature simply the 'formation of the body' (*lus kyi chags tshul* or *grub pa lus gnas*), a topic that begins with a discussion of conception and typically ends with the moment of birth. Similarly, in Tibetan literature there is no single, unambiguous term for 'embryo': that which we call the 'embryo' and the 'foetus' is in Tibetan literature referred to as the 'body (*lus*) forming in the womb', as 'that which resides in the womb' (*mngal gnas*), as the 'womb' itself (conflating the term for womb, *mngal*, with the embryo), or simply as the 'child' (*phru gu*). Despite this, the phenomenon of the 'embryological narrative'—that is, the detailed description of the developing human body in the womb—is widespread from the early days of Tibetan literature to the present. Although today we consider embryology to be unambiguously a topic of biology, science, or medicine—hence the appearance of this paper in this volume—how appropriate is this in the context of Tibetan literary history? This paper will suggest that embryology in medical and religious texts alike, particularly from around the fifteenth century onwards, is quite centrally a venue for discussing doctrines of Buddhist

morality and religious belief, and for promoting specific attitudes about human identity and the possibilities of and mechanisms for change.

The Primary Medical and Religious Literary Sources for Embryology

Although embryology was discussed in a wide range of Indian sources for a millenium before reaching Tibet,[1] only a relatively small number of these texts were available to Tibetans by the twelfth century, as I will outline below. Those that did make it across the Himalayas, however, represented a reasonably disparate range of traditions, and Tibetans were thus introduced to Indic embryologies through Āyurvedic medical, Buddhist *sūtric*, and Buddhist tantric texts.

The Indian medical text, *Yan lag brgyad pa* (*Eight Branches*), by Vāgbhaṭa (known in Tibetan by the names Pha khol, Pha gol, or Dpa' bo), reached Tibet by the eleventh century.[2] Its chapter on embryology covers topics such as the formation of the embryo, determination of the embryo's sex, the features of healthy reproductive fluids, ceremonies for conception, and rituals to ensure conception of a male child. The general structure of this Āyurvedic book is loosely replicated by the Tibetan medical text, the *Rgyud bzhi* (*Four Tantras*), and many of its particular teachings had a lasting influence on Tibetan medicine.[3] Despite the *Eight Branches*' status as one of the most widely cited sources in Tibetan medical texts subsequently, however, in many respects its authority is disregarded in the context of embryology.

In keeping with the pan-Indian philosophical preoccupation with foetal development, various Indian Buddhist texts, such as the *Abhidharma*, also include descriptions of the mechanics of conception and the process of fetal development. Among Buddhist *sūtras*, the source for embryological detail most heavily utilised by Tibetan writers is the Mahāyāna Buddhist *sūtra* known as the *Mngal du 'jug pa* (*Entry into the Womb*).[4] In this text the Buddha explicitly describes to his brother Nanda the factors necessary for conception and the entire

[1] For a summary of these, see Dasgupta 1975(2): 302–91, and Kumar 2000.

[2] Pha khol 1989. For a translation into English from the Sanskrit, see *Vāgbhaṭa's Aṣṭāṅga Hṛdayam Śutrasthāna*, 1996. A discussion of the text's provenance and authorship can be found in Vogel, 1965.

[3] *Bdud rtsi snying po yan lag brgyad pa gsang ba man ngag gi rgyud* 1993. See Dan Martin's article in this volume for comments on the relationship between these texts.

[4] *Tshe dang ldan pa 'dga' bo la mngal du 'jug pa* 1981. The Chinese translation of this text was translated into German in Huebotter 1932.

embryogenical process. This *sūtra* is extensively quoted by most authors who write about embryogenical development in both medical and religious traditions in Tibet. Another important class of Buddhist texts that served as a source for Tibetan authors discussing embryology is the Indian *tantras*. Meditation practices modeled after human conception, development, and birth—which are therefore themselves described in lesser or greater detail—are evident in many Indian Buddhist *tantras* and their exegeses.

India was not, of course, the only source for knowledge in Tibet. Some of the earliest medical practices by Tibetans themselves—such as healing rituals using the *gzi* stone and fire, and the practice of trepanation—are described in pre-Buddhist texts.[5] However, I am not aware of early accounts of embryogensis in these sources. An early, reputedly non-Indian, text with a substantial account of embryogenesis is *Sman dpyad zla ba'i rgal po* (*King of the Moon*). A Chinese version of this text is said by some scholars to have been translated into Tibetan at the request of Khri srong lde btsan.[6] The rendition of *King of the Moon* now available from Dharamsala, offering a version of the text said to be a translation from Sanskrit, includes a detailed account of embryonic development that is unlike any other embryogenical account that I have seen.[7] However, interestingly, I have never seen it cited as an authoritative source on embryology by Tibetan authors subsequently. While we might expect significant influences from Chinese sources on Tibetan embryology, in fact this has been difficult to determine. In discussions of embryology found in either religiously or medically oriented texts, Tibetan authors do not credit Chinese traditions with contributing information on the topic, despite the large numbers of Chinese medical scholars said to have been active in Tibet. The few available secondary sources describe Chinese embryological systems that are significantly different than anything seen in Tibetan literature, however, and thus it is difficult to posit any influence there.[8]

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[5] Skal bzang 'phrin las 1997: 32–39.

[6] Mention of this text in its various incarnations occurs in most Tibetan medical histories; for a summary of its various editions and their provenance, see the discussion of a contemporary medical historian in Byams pa 'phrin las 1996: 6–7. Fernand Meyer discusses this text in Dorje and Meyer (eds) 1992(1): 161.

[7] *Sman dpyad zla ba'i rgyal po* 1994.

[8] For a summary of early Chinese embryological theories, see Kinney 2003. Addressing the issue of why Chinese influence on Tibetan medicine is so difficult to trace, the contemporary medical historian Yongdrol Kangbu Tsongkha speculates that

At the time of the second diffusion, therefore, Tibetans had access to a range of sources on the topic: medical and religious, exoteric and esoteric. Human anatomy, physiology, and obstetrics formed the context for embryology in Vāgbhaṭa's medical text. Buddhist teachings on ethics justified narratives of embryology in the Buddhist *sūtras*. The *tantras* taught embryology as a technique of spiritual growth through ritual and meditation. How did Tibetan scholars beginning to compose their own texts at this point in history decide which approach was correct? Or, is this even the right question to ask?

Tibetan-authored Embryologies in Religious and Medical Literature

I will begin by commenting briefly on the context of embryology in indigenously Tibetan literature from the eleventh and twelfth centuries onward—first as it appears in religious writings, and then as it exists in medical literature. Spanning many centuries and a wide range of literary sub-genres, writing on embryology is found across all sectarian classifications of Tibetan religion. Embryological accounts in religious texts are often different in both structure and content than those found in medical texts, and they differ widely from each other as well. The Bka' rgyud founder Sgam po pa bsod nams rin chen (1079–1153), for example, although said to have been a medical scholar in his younger years, interestingly does not acknowledge medical models of embryology at all in the embryology that is present in his text, the *Dam chos yid bzhin nor bu thar pa rin po che'i rgyan* (*Jewel Ornament of Liberation*).[9] Quite unlike esoteric texts for which embryology provides a positive model for spiritual rebirth, Sgam po pa uses the misery of gestation and birth as a means of frightening people into religious practice.

Embryology is very commonly found in texts about the Buddhist path. An example of such a text is the *Rgyud kyi mngon par rtogs pa rin po che'i ljon shing* (*Great Jeweled Wishing Tree*), by the Sa skya scholar Grags pa rgyal mtshan (1147–1216), a contemporary of the

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due to the strong influence of Āyurveda on Chinese medicine during the fourth to ninth centuries, most of the Chinese doctors in Tibet, many of whom were also Buddhist monks, were in fact teaching systems of medicine more closely related to Indian Āyurveda than to indigenously Chinese medicine. Yongdrol Kangbu Tsongkha, unpublished manuscript. This fascinating suggestion certainly warrants further research.

[9] This is available in several English translations, among them Herbert Guenther 1971.

medical scholar G.yu thog yon tan mgon po (1112–1203).[10] Grags pa rgyal mtshan is the author of at least one medical text[11]—like Sgam po pa, he is one of many religious scholars of the time trained in medicine as well. Grags pa rgyal mtshan's embryology begins with a summary of the traditional Buddhist four types of rebirth—miraculous, egg-born, moisture-born, and womb-born—and an explanation of the causes of conception. His account of embryonic development addresses both coarse and subtle body aspects, and it precedes a detailed explanation of the tantric anatomy of *maṇḍalas*, circulatory channels, and winds. This account of embryology differs vastly from the narratives found in medical texts; his presentation of conception ignores the role of the natural elements, his descriptions of gestation and adult physiology do not mention the three humours, and so on.

Another important source for embryological information is the *Zab mo nang don* (*Profound Inner Meaning*), a Bka' rgyud text on yogic physiology and practice by Rang byung rdo rje (1284–1339).[12] This is a very commonly cited authority on embryologic topics in the important *Four Tantras* commentary by Zur mkhar blo gros rgyal po (1509–1579), the *Mes po'i zhal lung* (*Transmission of the Elders*).[13] Less than a century later, the Rnying ma scholar Klong chen 'rab 'byams pa (1308–1364) included some very long embryological accounts in his religious writings. His *Tshig don mdzod* (*Treasury of Precious Words and Meanings*) ignores completely the structure of the *Four Tantras* or any other known early medical embryological sources from India or Tibet, however; nor does it consider any of the most important embryological topics in those texts.[14]

These are but a few early Buddhist texts in which embryology is discussed—there are many others, and a full accounting of them is far beyond the scope of this paper.[15] Over the next several centuries in Tibet, embryology continued to play an important role in philosophical and religious literature of all sectarian persuasions. What is of note here, is that clearly the composition of embryology in Tibet was far

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[10] Grags pa rgyal mtshan 1968: 59a–65b.

[11] Grags pa rgyal mtshan 1966.

[12] Rang byung rdo rje 1970.

[13] Zur mkhar pa blo gros rgyal po 1989.

[14] Klong chen pa 1983. This text is translated in Germano 1992.

[15] I have discussed the embryologies of these and other writers in my doctoral dissertation and in several forthcoming articles (Garrett 2004 and forthcoming).

from straightforward. Despite the oft-spoken-of Tibetan author's impulse to form intellectual alliances with India, embryology was clearly a topic with which these writers could be creative. What this says about embryology, I will address below.

Embryology in religious texts is tied to explications of religious practice—either practices of morality, in which the horrors of the womb are used to frighten the audience into certain types of behaviour; or contemplative practices, in which meditators attempt a symbolic (or real) rebirth as a more enlightened being. In medical texts, by contrast, embryology has little to do with discussions of the *practice* of medicine. I will say a few words now to place embryology in the context of medical literature as a whole. What types of topics are included within the scope of medical literature in Tibet prior to the seventeenth century?

The majority of Tibetan medical works address nosology, pharmacy and *materia medica*. Nosological texts are descriptions and classifications of specific diseases, typically composed in the manner of a reference. Texts on pharmacy and *materia medica* describe the identification, collection methods, preparation, and application of medicinal substances. Other texts that we might also call reference works include dictionaries of specialised medical terminology. Interestingly, although there are countless texts devoted to pharmacy or nosology, there appear to be relatively few texts devoted exclusively to discussion of the structure or function of the human body itself. Several chapters of the *Bshad rgyud*, the second book of the *Four Tantras*, covering embryology and adult anatomy and physiology—and then their many commentaries—are the primary examples of this type of medical writing. Aside from this, there are lists of dynastic period texts in Sangs rgyas rgya mtsho's medical history, *Gso rig sman gyi khog 'bugs*, that suggest that human dissection was a topic addressed by the occasional author, and there are references to documents that appear to include medical drawings, which, certainly, are ways of describing the human body.[16] What I am proposing here, though, is that the focused discussion of embryology, anatomy and physiology for their own sake (that is, not in the context of discussing moxibustion, for example)—seems to be rare in medical

[16] This observation is based not on examination of the texts in question but by their titles alone. For lists of texts with titles such as *ro bgra 'phrul gyi me long, ro bgra thu gu dgu sbyor, and byang khog grems kyi mdo*, see Sangs rgyas rgya mtsho 1994: 154–55. Also see Meyer 1992: 11. Some of these early sources for medical iconography are also mentioned in Bolsokhoyeva 1993: 31–32.

literature, aside from its existence in the chapters of the *Four Tantras' Bshad rgyud* and the many subsequent commentaries on those chapters.

Reading Embryology in Tibetan Medical Literature

Now that I have outlined briefly where embryology occurs across Tibetan literature, what I will focus on in the rest of this paper is the suggestion that Tibetan embryology is not most fruitfully approached as 'science' or 'medicine' in the positivist Euro-American sense. Rather, I propose that embryology—that is, those discussions in Tibetan texts that focus explicitly on the development of the human body from conception until (re)birth—may be most productively read as conveying 'narrative truths'.[17] When we think about how to approach the wide range of embryologies in Tibetan literature, therefore, we might do more than ask whether embryos 'really' grow as these narratives say they do; indeed, we might ask whether these narratives mean to tell the story of how real embryos grow at all.

In calling Tibetan embryologies 'narrative' I am suggesting, among other things, that they partake of many of the attributes we normally ascribe to a story. Hayden White summarises four such attributes, most of which can be seen to varying degrees in Tibetan embryologies: a central subject; a well-marked beginning, middle and end; an identifiable narrative voice; and the suggestion of a necessary connection between one event and another.[18] One, in most Tibetan embryologies the central subject is purportedly the developing embryo; in cases where symbolism is explicit, the subject may alternatively be the contemplative who is meant to undergo the spiritual transformation described embryologically. Two, embryological accounts certainly have a well-marked beginning, middle and end: they invariably begin with a description of conception, always present some information about the process of development throughout gestation, and commonly end with

[17] I use this expression in order to value the truth status of Tibetan statements about embryology and to suggest that we must question our understanding of 'truth' in this context by considering how something comes to be true and what it means for something to be true. By attending to how embryology is narrated (examining its 'narrative truth'), I am proposing that embryology in Tibetan literature becomes much more richly interesting when viewed from a perspective other than the naive realism of the commonsense biomedical or scientific orientation.

[18] White 1980: 7.

the occurrence of birth. Three, many embryologies have an identifiable narrative voice, commonly that of a religious scholar or teacher (but rarely that of a medical clinician). And finally, Tibetan embryologies are concerned with the necessary connections between the events of gestation and how those connections take place. I have gone into some detail on each of these elements elsewhere,[19] so in the pages remaining I will address briefly only the question, Who is the central subject of embryological narratives in Tibetan literature?

Like anything else, Tibetan embryologies can be interpreted on various levels. The embryo characterised in Tibetan narratives does not necessarily refer to the literal (even if fictional or idealised) embryo. As I have mentioned, many embryological stories depict Buddhist practitioners of morality and meditation who, beginning with spiritual qualities that are embryonic in achievement, undergo the soteriologically charged contemplative activity of gestation and rebirth. The stories about these characters are conflicting, however: in one model, such as that of Sgam po pa, the suffering of gestation and the agony of birth are used to encourage religious practice; in another model, such as that of Klong chen pa, gestation and rebirth are viewed positively as opportunities to reach new spiritual attainments. Because this is a volume on Tibetan medicine, however, I will write briefly about how medical texts present the subject, or main character, of their embryological narratives, and what this says about the presence of embryology in medical literature in general.

Beginning with the obvious, the embryo is something that will grow into an ordinary adult body. At some point mid-way along the gestational process, it becomes a discrete body-mind unit, with limbs, skin, facial features, sexual characteristics, mental attitudes, and so forth. In general, in Tibetan medical theory, ordinary adult bodies are maintained by a variety of systemically self-organising processes. Discussions of physiology tell us that the substances of the body are sustained by the digestive process (which makes the internal condition of the body reliant upon substances of the world in the form of foods), and by the body's interaction with the natural environment. Guided by physiological processes of activity, vitality, and stability—in other

[19] See my doctoral dissertation, now under revision for publication.

words, the three humors—the body is functionally organised.[20] Thus this body is an integrated, coherent totality that adapts to internal and external environmental modification.

To this end, Tibetan embryological narratives semantically charge the human body in various ways. For example, Tibetan medical embryologies in particular educate their readers about gendered bodies.[21] The topic of sex or gender determination stimulates a lot of discussion in Tibetan medical commentaries such as those by Skyem pa tshe dbang, in the fifteenth century, and Zur mkhar blo gros rgyal po, in the sixteenth century.[22] The sources these authors were drawing on provided several theories on how the developing embryo acquires a particular set of sexual characteristics. Quite unlike the *Eight Branches* and *Four Tantras'* schemes, where newly conceived embryos were of ultimately indeterminate sex for at least three weeks, in the *Abhidharma* and *Entry into the Womb sūtra* traditions, it was essential to conception itself that sex identification be made—without sexual characteristics, a new being could not even be conceived. While in the *Four Tantras* tradition this *Abhidharma* model was not considered conclusively authoritative, many (but not all) religious embryologies did repeat the notion that emotions of aversion and attraction toward the two parents are central to the success of conception and the formation of a sexually defined and therefore gendered human being.[23] Medical commentaries such as those of Skyem pa tshe dbang and Zur mkhar blo gros rgyal po discuss a variety of notions on sex determination and go into some detail on

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20 Loizzo and Blackhall interpret the three humours as "three aspects of self-organization [that] may best be conceived as systemic aspects of activity, vitality, and stability" (Loizzo and Blackhall 1998: 313).

21 Although the terms are not synonymous, Euro-American theorists have debated the precise distinction between the terms 'sex' and 'gender', and in common parlance the two are often used interchangeably. 'Sex' typically refers to the biological aspects of being male, female, or, in the case of South Asian literature, which generally describes three types of genital presentations, 'hermaphrodite' (*ma ning*). 'Gender' typically refers to the behavioral, social, and/or psychological features of sexed individuals. 'Sex' emphasises the 'objective' marker of a particular set of genitalia on the body, whereas 'gender' is a more interpretive term that may refer to a person's social status and behavior. In the case of Tibetan embryology, my point here is that the texts go beyond an objective assignation of genitalia to a social valuing of one set of genitalia over the others, and thus they are speaking about gender as well as sex.

22 Skyem pa tshe dbang 2000 and Zur mkhar pa blo gros rgyal po 1989.

23 For example see Grags pa rgyal mtshan 1968: 59a. Klong chen pa does not mention sex identification at all. For an interesting discussion of various classical Greek views on sex determination, see King 1998: 8–9.

how you can change the sex of the fetus to that of a boy. The assignation of sexual characteristics is clearly not a semantically neutral issue, and thus the characterisation of the embryo goes beyond a description of genitalia to a sociocultural and ideological statement about gendered bodies and their relative value.

Embryology also defines bodies as 'defective' or normal. Medical texts generally claim that impurities in the male or female reproductive substances lead to failure to conceive. Some texts, however, such as the commentaries mentioned above, state that conception may occur, but these impurities will cause the generation of a child with physical deformities, such as a cleft lip, extremely short stature, or too many or too few limbs or sense organs.[24] Such discussions provide interesting evidence of Tibetan medical notions of physical imperfection and normalcy. Note, for example, that birth as a 'hermaphrodite' (*ma ning*) is not classified as physically defective; nor is the female form explicitly labeled a defective male, as in early Greek medical literature. Still, however, boy children are clearly considered more desirable than girl children, and in medical texts in general, women's bodies are considered different enough from men to warrant special nosologies. 'Normal' bodies are without question male bodies.

Human bodies are thus semantically charged structures that are gendered and normalised by embryological narratives. They are also defined by medical commentators in the *Four Tantras* tradition as interdependently harmonised with their environment. Unlike many Euro-American cosmological traditions that focus on the cosmos as an entity distinct from the individual, Buddhist cosmology is explicitly concerned with defining the interactive relationship between the human individual, his or her environment, and the cosmos. As is well known, an explicit correlation is made in many Asian traditions between the generation of the universe and the generation of the individual. A variety of thematic and rhetorical elements demonstrate the commitment of many writers to using embryology to communicate the inseparable nature of the individual and the cosmos. In most Tibetan accounts of conception and fetal development, the natural elements, which organise and direct the universe and everything that exists within it, play an essential role. Successful conception is said to result from the mixture of the male 'reproductive substance' (*khu ba*), female 'blood' (*khrag*),

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[24] For example, see Skyem pa tshe dbang 2000: 128.

and the transmigrating being's 'consciousness' (*rnam shes*), interacting with the energetic processes of the five elements inherent in those three substances. Medical embryologies thus tell us that humans are made up of the same stuff as the universe. This is not something that goes without saying, though, interestingly, and the precise role of the elements is an important topic of discussion in medical embryological writings. Indeed, the medical commentator Zur mkhar blo gros rgyal po is highly critical of those who neglect the importance of the elements in embryology, despite the absence of the elements in Vāgbhaṭa's *Eight Branches*, one of his primary medical sources in other contexts.[25]

Embryology in Tibetan medicine is a story that identifies and defines a certain type of human being. While Tibetan physiological theories are diverse and often contradictory, what they have in common, for the most part, is a sense that the adult body is to be characterised by a cosmologically harmonised functional adaptability and by structures that are semanticised by sociopolitical hierarchies or religious ontologies. These characteristics can be seen to inhabit the human body from its origins in the womb. Embryological narratives give human bodies gender, semantically charging the fetus on the basis of its sexual organs. In these narratives human bodies are defined as defective or normal, again shaping the body in ways that are not morally neutral. The human is said to be formed by adaptively interacting with its environment, suggesting that the border between the individual and its environment is contextualised and fluid. The embryological narrative is a tool used by Tibetan medical writers not so much to describe what is, but to prescribe what should be, in the effort to articulate acceptable models of human identity and change.

Conclusions and Speculations

Finally, I have two general, somewhat open-ended conclusions to make. One, I commented briefly that in religious literature, embryology occurs mainly in the context of discussions of religious practice, or 'religious therapeutics'. Embryology is thus a way of talking about the Buddhist path. (As the topic for another paper, I might hypothesise therefore that the increasing popularity of the *lam rim* genre after the second diffusion might have something to do with the growing popularity of embryology in religious literature.) In medical texts, however,

[25] Zur mkhar pa blo gros rgyal po 1989: 107.

embryology appears to have little if anything to do with discussions of the *practice* of medical therapeutics, or with the healing of disease, as we think of it. For medical authors by the fifteenth century, embryological narratives had become occasions for working out some of the stickier issues in Buddhism—in other words, embryology appears to have become a place for medical writers to do a bit a philosophising. What does this tell us? I would say that this may tell us that embryology—and I would add adult anatomy and physiology too—may be most fruitfully classed less as medical topics, than as Buddhist religio-philosophical ones. Or, if this suggestion is problematic, perhaps we can simply say that embryology, anatomy and physiology are topics that occur in a different way—or serve a different purpose—in Tibetan medical literature than do topics like pharmacy and nosology. Here it will serve us to recall that the study of the creation and structure of the human body in the context of medicine has a particular history in our own culture. The classicist Ludwig Edelstein suggests that in early Greek medicine, anatomical knowledge in general played a very small role in the practice of medicine—knowledge of the body was not essential to the practice of medicine.[26] Kenneth Zysk has noted that human anatomy was a topic taught in sections of the Pāli Canon's *Sutta Piṭaka* that deal with ascetic discipline, and not in the medical sections of the *Vinaya*.[27] In his *History of Indian Philosophy*, Dasgupta claims that the study of anatomy had almost ceased in Indian medicine by the time of Vāgbhaṭa.[28] Thus, it is possible that the resurgence in interest in theorising about the human body in Tibetan medicine by the fourteenth–fifteenth centuries is a sign of the 'Buddhification' of Tibetan medicine. In other words, the human body is a hot topic in medicine because it is a hot topic in religion, and not the other way around.

And finally, I have suggested that reading Tibetan embryology as narrative, rather than as empirically verifiable (or not) scientific observation, shows it to be a lucrative and deeply expressive way for scholars to communicate truths about human identity, continuity and change. Again, as the topic of another paper, we might go so far as to see an important parallel between the way embryological narratives construct models of identity, continuity, and change, and the way historical narratives do so. For the scholar, if embryology is a narrative that defines

[26] Edelstein 1967: 261–66.
[27] Zysk 1991: 34.
[28] Dasgupta 1975(2): 433. On this topic also see Grmek 1998.

individual identity, history, surely, is the narrative that defines social or institutional identity. Notions of ethics, causality and geometric space shape the creative construction of social identities through historical narratives just as they do the creative construction of personal identities through embryological narratives. Just as it is of limited value to read embryological narratives only for information on how embryos grow, there is likewise much more to be understood from a historical narrative than simply what events occurred.

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BRIEF OUTLOOK: DESIDERATA IN THE STUDY OF THE HISTORY OF TIBETAN MEDICINE

HENK BLEZER *ET AL.*

This brief outlook on research in the history of Tibetan medicine is the result of deliberations over a period of several years by five researchers,[1] aided by a board of five advisors in 2004,[2] in preparation of future research work on the history of Tibetan medicine. We decided to publish a preliminary report at this point in time, in the hope that it will articulate and eventually help redress the present scarcity of reliable and comprehensive academic research and publication on the history of Tibetan medical traditions. This contribution is therefore not intended as a survey or review of the present state of research, highlighting its merits, but as an attempt to chart out the most apparent lacunae in the field in order to formulate reasonable and feasible longer-term research targets.

Anyone who wishes to familiarise themselves with the history of Tibetan medicine will soon discover that the academic discourse on the subject still is in a nascent and fragmented state. The few academic monographs presently available cover a limited range of synchronic and diachronic issues.[3] Surveys have only appeared as brief monograph introductions or as popular, often traditionalist presentations with limited academic merit. At present the most urgent *desideratum* in the field therefore is broad and groundbreaking research; this outlook is intended to help define a framework for future work on the history of Tibetan medicine.

The present state of academic knowledge has been developed by a surprisingly small group of dedicated and productive scholars. The amount of work that needs to be done is daunting. Over more than a

[1] Alphabetically: Henk Blezer (Leiden), Olaf Czaja (Leipzig), Frances Garrett (Toronto, beginning stages; later: Ilona Manevskaia, St. Petersburg/Leiden), Alex McKay (London), and Mona Schrempf (Berlin); most contributed to this volume.

[2] Harm Beukers (Leiden), Jan Meulenbeld (Groningen), Fernand Meyer (Paris), Geoffrey Samuel (Cardiff, see contribution here), and Wim Stokhof (Leiden).

[3] See, e.g., Meyer 1988 and Taube 1981.

millennium, Tibetan medical traditions have produced a vast corpus of literature analogous in complexity to the medical scholasticism of India, China, or Greece, and they have developed in highly involved dependencies on the latter, which still require illumination. Today, Tibetan medicine is not only practised widely in Asia, but its use is growing in Europe and North America as well. A history of such an important and highly diverse body of knowledge can only be accomplished satisfactorily if a carefully chosen range of major periods and relevant disciplines are addressed in conjunction, which, ideally, requires a multidisciplinary team of specialist researchers working collaboratively for a period of several years.

RESEARCH TARGETS

Looking at the present academic discourse on Tibetan medicine as a textual scholar, one cannot help but be struck by the prevailing lack of detailed analytical (rather than encyclopaedic) knowledge of even the most essential textual sources of Tibetan medicine. The precise origins, contexts, textual history and intertextuality, even of such basic sources as the *Rgyud bzhi* or *Yan lag brgyad pa*, in recent decades do not seem to have raised much academic appetite and at the beginning of the third millennium are still awaiting satisfactory and in-depth coverage. Presently we still subsist on a few excellent but preliminary or only tangential treatments of several decades ago.[4] As much as the central texts of Tibetan medicine still await proper philological and historical attention, within our research group it also soon became apparent that there is another area that perhaps provides even more uncharted terrain, the human chains that transmit medical expertise: medical teaching lineages, in all their various forms. For a proper and balanced understanding of the development of medical knowledge in Tibet, research on various aspects of medical lineages forms an indispensable complement to text-historical work, and an interdisciplinary approach is therefore essential. As is well known, Tibetan historical writing (on medicine) mostly touches on precisely those two issues, chronology of transmission (mostly codified in texts) and lineage. Thus we have had to conclude

[4] See, e.g., Emmerick, Meyer, and Taube; for the *Yan lag brgyad pa*, see Emmerick 1998, Kirfel 1937–41 and Vogel 1965.

that, in order to redress the most urgent lacunae in the field effectively, the first desideratum is a qualitative study of processes of the (re)construction of Tibetan medical knowledge as apparent in text and lineage. We should try to do this in a comprehensive manner and aim at covering no fewer than six interlinking formative periods. Based on this, we can formulate seven targets for future research.

1. First, we need to perform a critical analysis of the (re)construction of medical knowledge in Tibet and reveal the composite, variegated and dynamic nature of Tibetan medical traditions—this will redress the uncritical nature of available popular works on Tibetan medicine. Many works in the field are shaped by essentialist religious (Buddhist) and polished monolithic, syncretistic views of Tibetan medicine, standpoints that evolved in Tibetan literature after the establishment of 'orthodoxy' in the 17th–18th cent. CE. Even as academic publications they often speak from persistently traditionalist or (re)invented 'traditional' perspectives. Prevalent (emic and etic) views on religious and sectarian affiliation of medical expertise urgently need to be questioned.

2. We need to integrate recent synchronic and diachronic data by juxtaposing anthropological expertise and historical disciplines. Anthropological and contemporary historical research will allow privileged access to the construction and transmission of medical knowledge in the recent past with reference to the present-day and to its social, political and economical context, which are more difficult to access in earlier phases.

3. We should consider the wider context of the political and religious sectarian forces at work in the history of Tibetan medical literature.

4. We should also consider the neglected but very significant influence of the Bon po community on post-first-millennium Tibetan medicine.

5. Elite perspectives on Tibetan medicine, which are mainly based on a selection of 'canonical' texts and are cultivated particularly in larger medical teaching institutions, need to be systematically challenged by collecting data on small-scale lineal and orally based transmissions.

6. We should consider the Tibetan methods of hermeneutics and scholasticism when analysing diverging commentaries on and interpretations of Tibetan medical treatises.

7. It is necessary to work toward a reliable academic handbook on the history of Tibetan medicine, which coherently covers all main periods: a standard work of reference.

SIX KEY TEMPORAL FOCI

Targeting a sample of six key formative periods allows us to achieve a balance between comprehensiveness and depth. The foci moreover display an inner coherence: each slot represents a period of major (re)construction of Tibetan medical knowledge. In addition most of the periods reflect tensions of assimilating 'foreign' influences.[5] For all periods attention is due to contextual social factors that are at play in the political and religious environments, as well as to scholastic hermeneutical issues of interpretation and composition of commentary. Each period moreover sheds light on 'identity issues' relevant to the transmission and practice of 'Tibetan medicine'.[6]

In the last part of this contribution, 'A Sample Case', I will look in some detail at the processes of canonisation and formation of orthodoxy in Tibetan medical traditions as they would become apparent in detailed analyses of the development of the main medical corpus of Tibet—the *Rgyud bzhi* with particular reference to the Bon po *'Bum bzhi*. This also can only be accomplished by adopting a broad and integrated approach, covering at least three of the six main periods: formation (11th-12th cent.), diverging interpretation (14th-17th cent.) and establishment of orthodoxy (17th-18th cent.).

The six periods are:

1. *The translation and assimilation of early medical literature in Tibet* during the period of the early diffusion of Buddhism (7th-9th cent. CE). Tibetan medical traditions are rooted in a variety of foreign medical systems. Contacts between the medical traditions of Tibet and India, China, Greece/Byzantium and Central Asia are reported starting the 7th cent. CE. This period is accessible mainly through later Tibetan historical sources. Some ground has already been covered (e.g., Beckwith 1979 and Taube 1981). The next logical steps are the study of newly discov-

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[5] E.g., the 7th–9th cent. CE exhibits Indian, Greek/Byzantine and Chinese influences; the 11th–12th cent. shows evidence of Chinese, Indian and other forces, as well as influences from Buddhist and Bon religious environments; the 17th–18th cent. CE demonstrates the homogenisation of diverse traditions into canonical scholastic texts; and the early modern and post-Mao era reveals an interplay between institutional and (mostly familial) lineage varieties of traditional medicine, biomedicine and the forces of modernity.

[6] Examples of such 'identity' issues are: Indian, Chinese or other provenance; religious-sectarian affiliation (e.g., Buddhist or Bon); institutionalised or (familial) lineage-based; elite or popular; traditional or biomedicine.

ered Tibetan sources (cf. Yangga's work, Harvard University) and the Herculean task of satisfactory coverage of Greco-Arab, Indian and Chinese sources.

2. *The formation of the first native Tibetan medical texts* in the period of the later diffusion of Buddhism (*phyi dar*, 10th–12th cent. CE), with a particular focus on the compilation and early transmission of the *'Bum bzhi* and *Rgyud bzhi*. A longer discussion of this period follows anon (see PERIOD 2). See also a contribution by Dan Martin to this volume on a unique and very interesting early history text (most likely date 1204) that is attributed to Che rje Zhang ston zhig po thugs rje khri 'od, the *Sman gyi byung tshul khog dbubs rgyal mtshan rtse mo 'bar ba*, which apparently predates the ascendancy to orthodoxy of the *Rgyud bzhi*. Also refer to the included article by Mona Schrempf. She has recorded traces of a still extant oral record on the transmission history of the *'Bum bzhi* and *Rgyud bzhi*; it would indeed be interesting to correlate her data with textual sources (from which in this case, one would presume, the record most likely ultimately derives).

3. *The arising of the main commentarial traditions and schools of interpretation*, 14th–17th cent. CE. A longer discussion of this period follows anon (see PERIOD 3). Here I should like to refer to the included article by Theresia Hofer. Her presentation of unique oral data on the transmission history of the Byang lugs speaks as an eloquent advocate for the importance of joint work on textual and oral sources.

4. *The birth of classical orthodoxy*: the codification and canonisation of Tibetan medical tradition by the Fifth Dalai Lama and his Regent and the establishment of Lcags po ri medical college in the late 17th and early 18th cent. CE. A longer discussion of this period follows anon (see PERIOD 4). On this period see also the included article by Olaf Czaja.

5. *Encounters with modernity and exile* in the 20th cent. CE. Research on the introduction of biomedicine into the Indo-Tibetan Himalayas is presently pursued by Alex McKay in a project funded by The Wellcome Trust (2002–5). In the near future (starting 2005) he may also include analyses of the impact of biomedicine on Tibetan medical traditions, ideas, and strategies of resort, during the 20th century. See also his contribution elsewhere in this volume.

6. *The revival and reinvention of Tibetan medicine* since the 1960s. Using case studies pertinent to all the other slots, Mona Schrempf, the editor of this volume on Tibetan medicine, in a project funded by the DFG/Humboldt University (2004–8), investigates the impact of biomedicine and modernity on the rural practice of Tibetan medicine as well as continuities with older Tibetan medical notions and practices as transmitted through medical lineages in Tibetan areas of present day China. A preliminary outcome based on recent fieldwork is included in this volume.

A Sample Case: *The Fourfold Tantra*: Formation, Interpretation and Canonisation

The *Fourfold Tantra* (*Rgyud bzhi*) no doubt provides the best showcase for the curious state of academic neglect outlined above. It is the central textual corpus codifying Tibetan medical expertise and has formed a logical starting point for almost every presentation of traditional Tibetan medicine. An outline of its history falls nothing short of a true success story. Since the 11th–12th cent. CE, its most likely date of composition, the *Rgyud bzhi* together with its commentaries and dependents quickly moved to the centre of the literary Tibetan medical scene. Its ascendancy to an authoritative status can be traced to at least the 15th–16th cent. CE and became an indisputable fact by the 17th–18th cent. CE.[7] Yet, surprisingly, the textual and social history of the *Rgyud bzhi* until today remains largely unknown. It appears as a complex, composite and syncretistic text that in an intellectually daring synthesis incorporates medical knowledge from diverging medical systems (*inter alia*, from India and China).

The origins of the *Rgyud bzhi* have been quite controversial, not least of all in the Tibetan scholarly world. Some claim that it can be traced to the Buddha, while others, in polemical treatises, maintain that it is a later Tibetan creation (cf. Karmay 1989). Since Emmerick, in one of the very few academic studies on the topic (1977), pointed to the unlikelihood of the translation of the *Rgyud bzhi* from an Indian source, not too many in the academic arena still feel inclined to follow the thesis of Indian origins. Due to limited access to sources and their perceived opacity, Emmerick's work had to remain somewhat inconclusive. That opacity is partly due to the fact that academic scholarship has neglected the possibly important role that the Bon po community may have played in the formation of the *Rgyud bzhi*. Especially the textual history of the Bon po medical treatise called *'Bum bzhi*, a text very similar to the *Rgyud bzhi*, may well shed more light on the early formation of the latter.

Since the 1970s/1980s, hardly any new ground has been broken. Little if any attention has been paid to the complex political, social and religious forces that have shaped the *Rgyud bzhi* and its precursors, and have reformatted it, in commentary, into some kind of orthodoxy. In

[7] See Taube 1981, cf. now also Dan Martin in this volume, on the 13th cent. CE situation as apparent from Che rje's text.

most publications the *Rgyud bzhi* is stripped of such forces and is unjustly regarded as a text that can be understood without reference to its social history. At best, publications refer to old work by Emmerick or Taube, at worst they merely uncritically engage traditionalist perspectives. Yet Taube and Emmerick, however excellent their studies may have been, were hindered by limited access to relevant sources. Fortunately, the last decades have witnessed a dramatic increase in published Tibetan medical sources. Time has now come to tackle the problem of assimilation and construction of medical knowledge into the *Rgyud bzhi*. Such a project would involve at the very least three if not four of the mentioned periods.

PERIOD 2. At the beginning of the 2nd millennium a great variety of medical knowledge, which had been assimilated during the early and later diffusion of Buddhism, was integrated into the first native Tibetan medical treatises. This is the time that the *Rgyud bzhi/'Bum bzhi* took shape. We urgently need to investigate how in this period medical knowledge that fed into the *Rgyud bzhi/'Bum bzhi* textual complex passed through Bon po and Buddhist hands. The *Rgyud bzhi/'Bum bzhi* materials and their antecedents not only need to be examined with the eye of a textual scholar, but also open to the intellectual, religious and political realities of the period. It involves work on the main Tibetan medical sources: the *'Bum bzhi*, the *Rgyud bzhi*, and commentaries, with a special focus on their dependencies on earlier texts such as the *Yan lag brgyad pa* (*Aṣṭāṅga*[*hṛdayasaṃhitā*]; see Martin in this volume) and the *Zla ba'i rgyal po*. In this regard we also need to clarify the role of religious background and sectarian affiliation in the transmission of medical knowledge, which bears relevance to the other periods as well (see, e.g., Mona Schrempf in this volume). Proposed working hypotheses:

1. The Bon po *'Bum bzhi* contains earlier redactions of medical material very similar to that contained in the *Rgyud bzhi*, as is indeed variously indicated in emic narratives. Text-historically, it therefore makes more sense to compare sources such as the *Aṣṭāṅga* to the *'Bum bzhi* than to compare them to the *Rgyud bzhi* (cf. Emmerick 1977).

2. The Buddhist pedigree for the *Rgyud bzhi* seems problematic. Alternative derivation through Bon po medical practitioners is not unlikely. Surprisingly many relic-like references to Bon are 'still' extant in the *Rgyud bzhi* (see Karmay 1989).

3. The *Rgyud bzhi* is a highly syncretistic and composite text in which many influences are combined into an intellectually coherent system (see Meyer, e.g. 1992).

4. One or more texts called *Zla ba'i rgyal po* may be considered less successful syncretistic precursors of what the *Rgyud bzhi*, from a canonical point of view, more successfully became (see Meyer 2002). 'It' may be the first record or even the point of entrance of expertise on pulse analysis into the Tibetan medical system (see Meyer 1990b).[8]

Due to the central position of the *Rgyud bzhi* for Tibetan medicine, this period branches out to most of the later ones, as all these are deeply involved with editions, commentaries, lineages, etc. of the *Rgyud bzhi*, or with controversies regarding it.

PERIOD 3. Expertise in Tibetan hermeneutics is necessary to open indispensable and new perspectives on the history of reception of the *Rgyud bzhi* after the 12th cent. CE. This is a period of prolific textual production and growing sectarianism in Tibet. Around the 15th–16th cent. CE, the Byang and Zur lugs arise: two important schools of Tibetan medicine that will dominate the organisation of medical teachings for the next two centuries.[9] Research will have to deal with the existing variance in *Rgyud bzhi* interpretation in this period. The methods of writing commentary need to be described and analysed. This will provide an opportunity to investigate how the arising medical schools have managed to incorporate and adjust Tibetan medical knowledge by means of commentary and will illuminate the interpretative spin that certain authors were able to lay on the *Rgyud bzhi*, while remaining within the bounds of their hermeneutical traditions, and indicate which are the hermeneutical-didactical rules at work in this particular arena. All this takes a keen eye for the aspects of 'power' involved in the creation and use of (interpretative) texts. This will also shed significant light on the controversy whether or not the *Rgyud bzhi* is authentic Buddha word; a discussion that reaches back at least as far as the 14th cent. CE (Taube 1981:33) and continues up to this very day. This approach will establish a first framework for a history of reception the *Rgyud bzhi* and help putting the issue of its canonisation in a wider socio-historical context.

[8] Cf. a useful descriptive and comparative exercise by Yan Zhen and Cai Jingfeng in this volume, which incidentally helps underline the need for further historical-analytical work.

[9] The phrasing has profited from early input by Frances Garrett.

PERIOD 4.[10] This time-period seamlessly merges with the previous one. In mid-focus we find the Fifth Dalai Lama (1617–82) and his Regent, Saṅs rgyas rgya mtsho (1653–1705), and more in particular the latter's 'critical' edition of the *Rgyud bzhi* and his composition of the *Blue Beryl* (*Vaiḍūrya sngon po*) commentary, which, even today, is the most authoritative interpretation of the *Rgyud bzhi*. We need to evaluate in detail how the *Blue Beryl* achieved the position of influence that it still holds today (see also Olaf Czaja in this volume). Based on hermeneutical expertise the Regent's commentarial policies regarding the extant variance in interpretation and edition are to be investigated. Thus his scholarly output is considered within the historical context of the 17th–18th cent. CE and the consolidating power of Dge lugs pa school, asking how the *Blue Beryl* achieved a position of such influence. This will put the commentarial tradition in a wider context of social, political and economic realities. Proposed working hypotheses:

1. In the Regent's eclectic reading of earlier interpretations we can see the late (and still dominant) 'orthodox' interpretation of the *Rgyud bzhi* taking shape.
2. An in-depth study of the *Blue Beryl*, including its *Supplement* (*Lhan thabs*), will establish the Regent's hermeneutical policies and shed light on the extent of his 'authorship', the degree to which his position may have been pre-formulated in earlier medical literature.
3. The Regent's claim to have integrated the Byang and Zur lugs in his work is only partly justified. His position may moreover already have been formulated in medical literature that predates his scholarship.
4. The Regent's work should be evaluated in relation to activities at other contemporary medical centres, such as those of the 'Bri gung pa.

It is also recommendable to examine other contributions to Tibetan medicine by the Regent, such as his commission of a series of medical paintings and the establishment of the Chagpori medical school. Historical literature of a later date is necessary to reconstruct the medical education as it was first institutionalised and formed a precursor of the 20th century Mentsikhang Hospital. The study of the Chagpori centre obviously bears great relevance to the later Mentsikhang medical centres and connects this research to later time periods.

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10 The targets for this time period have been developed mainly by OlTibetans publically af Czaja.

EPILOGUE

The study of the history of Tibetan medicine may be relevant to more than just the field of (Tibetan) medicine. Here we have an extensive number of texts pertaining to Tibetan historical genres that are significantly less imbued by religious agendas than usual. This provides a unique perspective on the formation of some of those puzzling, multifarious and functionally diverse varieties of Tibetan historical writing that have largely been taken for granted and up until now remain poorly understood. Coming to grips with what exactly these Tibetan historical genres represent, what they try to communicate, how they have developed and how they functioned in their own contexts may be one of the most significant challenges facing Tibetan studies today. For tackling the specific problems that beset this line of inquiry we need to engage philosophy of history (e.g., work by Kapstein 2000), including a systematic investigation of Tibetan scholasticism and hermeneutics, literary theory (e.g., Gyatso 1998, Bjerken 2003 and ongoing work by the author) and anthropology, as much as we need to resort to purely historical and philological expertise. We also need to study other related historical literatures such as are extant in the Indian and Chinese realms of influence. In this respect the most revealing conjunction of nascent Tibetan and more developed Chinese historical expertise and sensitivities in Dunhuang sources deserves particular attention.

Some in our research group are working towards accommodating these targets into a scheme of coordinated research projects. For more information on its progress and regarding possible contribution kindly contact the editor of this volume or the author of this article.

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IN THIS VOLUME, FOR THE FIRST TIME TIBETAN Medicine is approached from a combination of anthropology and history. These two disciplines appear to be vital to come to understand Tibetan medical knowledge and practice as being complex, diverse and dynamic phenomena which reflect changing social and historical conditions at the same time while also appealing to or preserving an older canon of traditions.

Part One examines the impacts of various modernities in Tibet, the Himalayan borderlands and the Tibetan exile, including standardisation and scientization of Tibetan medicine. Part Two investigates the transmission and professionalisation of medical knowledge and its role in identity construction. Part Three traces connections between various body images, practices, and cosmologies in Tibetan societies and how mental and physical illnesses are understood. Part Four critically presents new or little known histories, commentarial practices, textual narratives and oral sources for investigating the history of Tibetan medicine.

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